Chart#:_____
For Office Use Only

Patient Information

Patient Name: _____Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Cell): _____Work:_____ Ext: _____ Best time to call: _____

Preferred appointment times: □ Morning □ Afternoon □ Evening □ Any Time □M □T □W □Th □F □Sat

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit_____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

□ AIDS	□ Excessive Bleeding	□ Liver Disease	□ Stroke
□ Allergies: _____	□ Fainting	□ Mental Disorders	□ Tuberculosis
_____	□ Glaucoma	□ Nervous Disorders	□ Tumors
□ Anemia	□ Growths	□ Pacemaker	□ Ulcers
□ Arthritis	□ Hay Fever	□ Pregnancy	□ Venereal Disease
□ Artificial Joints	□ Head Injuries	Due date: _____	□ Codeine Allergy
□ Asthma	□ Heart Disease	□ Radiation Treatment	□ Penicillin Allergy
□ Blood Disease	□ Heart Murmur	□ Respiratory Problems	□ OTHER:
□ Cancer	□ Hepatitis	□ Rheumatic Fever	□ _____
□ Diabetes	□ High Blood Pressure	□ Rheumatism	□ _____
□ Dizziness	□ Jaundice	□ Sinus Problems	□ _____
□ Epilepsy	□ Kidney Disease	□ Stomach Problems	□ _____

List of Medications:

Have you ever had any complications following dental treatment? □ Yes □ No
If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? □ Yes □ No
If yes, please explain: _____

Are you now under the care of a physician? □ Yes □ No
If yes, please explain: _____

Name of Physician: _____ Phone: _____

Do you have any health problems that need further clarification? □ Yes □ No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent, or guardian

Referral Information

Whom may we thank for referring you to our practice? □ Another patient, friend □ Another patient, relative
□ Dental Office □Yellow Pages □ Newspaper □ School □ Work □ Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: □ the patient's spouse □ the person responsible for payment

Name: _____

□ Male □ Female □ Married □Single □ Child □ Other _____

Social Security #: _____ Birth Date: _____

Phone (Cell): _____Work:_____ Ext: _____ Best time to call: _____

Address: _____

Street Apartment #

_____

City State Zip Code

Employment Information

The following is for: □ the patient □ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street City State Zip Code Phone

Insurance Information

Primary:

Name of Insured:_____ Is insured a patient? □ Yes □ No

Last First MI

Insured's Birth Date: _____ ID#: _____ Group #: _____

Insured's Address: _____

Insured's Employer's Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: □ Self □ Spouse □ Child □ Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured:_____ Is insured a patient? □ Yes □ No

Last First MI

Insured's Birth Date: _____ ID#: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer's Name: _____

Address: _____

Patient's relationship to insured: □ Self □ Spouse □ Child □ Other _____

Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. A service charge of 1%% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent, or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

2262 Pacific Coast Highway, Lomita, CA 90717 | (310)530-3790

Patient Name: _____ Date: _____

Email Address: _____

Internet Communication Consent

I grant my permission to Night Owl Dental to upload and store confidential patient information — including account information, appointment information and clinical information — to the secured web site for Night Owl Dental. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand Night Owl Dental and myself are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that Night Owl Dental is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand Night Owl Dental is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the Night Owl Dental web site with my ID and password. I also agree to immediately notify Night Owl Dental of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns. I also understand State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand Night Owl Dental will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my patient information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that Night Owl Dental has the right to monitor, retrieve, store, upload and use my patient information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand Night Owl Dental will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand Night Owl Dental CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ I have read the information above regarding the secured uploading of patient information to the web site for Night Owl Dental, and grant Night Owl Dental permission to securely upload my patient information to the web site.

_____ _____

Signature of patient, parent, or guardian (responsible party) Date

Relationship to Patient: _____

2262 Pacific Coast Highway, Lomita, CA 90717 | (310)530-3790

Consent for Use and Disclosure of Health Information (HIPAA)

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operation.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, healthcare operations and of the uses and disclosures we may make of your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any protected health information that we maintain.

Right to Revoke: You have the right to revoke this Consent at any time giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

☐ I have read the above conditions and treatment and payments and agree to the contents.

_____ _____

Signature of patient, parent, or guardian (responsible party) Date

Relationship to Patient: _____

Night Owl DENTAL

2262 Pacific Coast Highway, Lomita, CA 90717 | (310)530-3790

Financial Agreement

I voluntarily and knowingly request and consent to the services, treatments and/or procedures recommended by the dentist and to all diagnostic methods deemed appropriate by the dentist which may include, but not be limited to, x- rays, study models, imagery, and other aids. I authorize the dentist to perform all such services, treatments and/or procedures and to utilize all such diagnostic methods. Further, I acknowledge and understand that the dentist may engage the assistance of others in performing such services, treatments and/or procedures and in utilizing such diagnostic methods.

I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the services, treatments, procedures and/or diagnostic methods that have been recommended. I also understand that the use of anesthesia carries with it significant risks that have been explained to me.

I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by the dentist and others members of the dental office. I acknowledge that any insurance coverage or managed care benefit that I may have is based on a contract between my insurance company or managed care company and me, my spouse and/or my employer. The dentist is not a party to this contract and the services, treatments, procedures and/or diagnostic methods are provided to me. Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatments, procedures and/or diagnostic methods provided to me. As a courtesy to me, the dental office will bill my insurance company or managed care company and I acknowledge that I will remain liable for any and all amounts not paid by the insurance company or managed care company for any reason (including but not limited to the insurance company or managed care company declining coverage after initially approving it) or if the insurance company or managed care company fails for any reason to reimburse the dentist within 30 days after being billed by the dentist. I acknowledge that it is my responsibility to provide the dentist with my current insurance or managed care information and any changes thereto.

All returned checks will be subject to a $35 returned check fee. Any account balances that remain unpaid for 45 days from the date of service shall accrue interest at the rate of 18.99 percent (18.99%) per year and may be referred to a collection company or attorney. In the event this occurs, I understand that I will be liable for collection costs of 25 cents ($.25) per every one dollar ($1.00). Further, in the event any unpaid account balance is referred to an attorney for collection, I agree also to be responsible for all costs and reasonable attorney's fees incurred in connection therewith.

I consent to the dentist's use and disclosure of my health information to my insurance company or managed care company and any agent thereof. I hereby assign to the dentist all the insurance and managed care benefits due to me for the services, treatments, procedures and/or diagnostic methods provided to me and I authorize my insurance company and/or managed care company to make payment directly to the dentist for the costs associated therewith.

I further consent to be contacted by the dentist, any agent of the dental office, or any collection agency (or agent thereof) or attorney to whom an unpaid account balance has been assigned or referred by mail at any address that I provide to the dental office and/or by facsimile, email or phone number (whether a cell phone or landline) at any facsimile number, email address or phone number (whether a cell phone and landline) that I provide to the dental office or any agent of the dental office.

Patient Signature: _____ Date: _____

Print Name: _____

Guardian/Responsible Party, if minor: _____

Print Name: _____ Date: _____

Night Owl DENTAL

LIABILITY WAIVER for Dental Treatment

Novel Coronavirus (COVID-19)

Dr. JD Bilbao and team at Night Owl Dental remain steadfast in our commitment to provide care to the community we serve to keep our patients and families healthy as we continue to monitor the Novel Coronavirus (COVID-19) situation daily.

Our office is committed to continuing to operate for patients with emergency and essential needs during this time. It is critical we continue to support our healthcare community so patients with emergency and essential conditions do not stretch the capacity of our hospitals and urgent cares during our country's greatest time of need.We want to reassure you, our patient, your health and safety has always been our number one priority. It is our primary mission.

Please be assured, our practice has infection control policies, procedures and systems in place that meet or exceed the **Centers for Disease Control's** Standard Precautions for Dental Practices. This includes disinfecting operatories with hospital grade products in every room, after every patient visit.

As these are unusual times with uncertainties, Dr. JD Bilbao and team are requesting a mutual liability waiver for all patients who wish to receive treatment during the COVID-19 pandemic.

By accepting treatment today, Dr. JD Bilbao and team and our patient mutually agree to hold harmless any liabilities from possible exposure to the Novel Coronavirus (COVID-19).

By signing the attached agreement:
Dr. JD Bilbao and all active team members of Night Owl Dental will hold harmless and waive any liabilities related from possible exposure to COVID-19 from our patient and;

Our patient will also hold harmless and waive any liabilities related from possible exposure to COVID-19 from Dr. JD Bilbao and all active team members of Night Owl Dental.

If you do not wish to sign the agreement, we can reschedule your dental treatment to a future date when the Novel Coronavirus (COVID-19) has been deemed under control by the Centers for Disease Control.

Our clinicians are available to answer any questions you might have.We remain committed to your health and well-being.

Thank you.

JD Bilbao, DDS

2262 Pacific Coast Hwy., Lomita CA 90717 Tel: 310.530.3790 Fax: 310.530.3246

Night Owl DENTAL

LIABILITY WAIVER AGREEMENT

for Dental Treatment during Novel Coronavirus (COVID-19) Pandemic

By Accepting dental treatment today, _____, 2020,

I, _____ hereby agree to release, indemnify, defend and hold harmless on behalf of myself (and any minor children for whom I have the capacity to contract) Dr. JD Bilbao, DDS, its officers, agents and employees from and against any and all liabilities, claims, penalties, losses, or expenses (including attorneys' fees), of any kind or nature whatsoever, whether related to bodily injury, any other form of injury or loss to myself (and to any minor children for whom I have the capacity to contract), caused any possible exposure to the Novel Coronavirus (COVID-19).

I acknowledge the possible exposure to Novel Coronavirus (COVID-19) can be dangerous, even fatal. As a result of signing below, I am accepting those risks for myself and for any minor participants for whom I can contract. I give permission to Dr. JD Bilbao, DDS,its officers, agents and employees to provide dental treatment.

I hereby attest to the following:

1. I am not currently experiencing a fever, cough, or difficulty breathing.

2. All members of my household are not currently experiencing a fever, cough, or difficulty breathing.

3. I have been limiting social distance, including handshaking, as a means of decreasing possible transmission of the Novel Coronavirus (COVID-19).

4. I, and all members of my household have not traveled outside of the US to areas considered level-3 precaution by the Centers for Disease Control. This includes the following countries: Italy, South Korea, Iran, and China in the past 90-days.

I understand I mayreschedule my dental treatment to a future date when the Novel Coronavirus (COVID-19) has been deemed under control by the Centers for Disease Control.

_____ _____

PRINT NAME SIGNATURE

_____

DATE

2262 Pacific Coast Hwy., Lomita CA 90717 Tel: 310.530.3790 Fax: 310.530.3246

Patient: _____ DOB: ____/____/_____
Today's date: ____/____/_____ BMI: _____

Have you been told you have sleep apnea?	Yes ☐	No ☐
Have you been told to wear a CPAP or any other device for breathing at night?	Yes ☐	No ☐
If yes, do you wear it every night for the entire night?	Yes ☐	No ☐
Do you take medication, supplements, or over-the-counter substances as sleep aids or headache relief?	Yes ☐	No ☐
Do you feel rested in the morning?	Yes ☐	No ☐

Please check if you have any of the following:

Heart Disease ☐	Insomnia ☐	Diabetes ☐
Headaches ☐	Depression ☐	Urination at night (nocturia) ☐
Acid Reflux ☐	Stroke ☐	Tooth grinding ☐

STOP BANG SCORE:

Do you SNORE?	Yes ☐	No ☐
Do you feel TIRED?	Yes ☐	No ☐
Has anyone OBSERVED you stop breathing during sleep?	Yes ☐	No ☐
Do you have or are you being treated for high blood PRESSURE?	Yes ☐	No ☐
Is your BMI > 30?	Yes ☐	No ☐
AGE: Are you > 50 years old?	Yes ☐	No ☐
Is your NECK circumference > 16"?	Yes ☐	No ☐
GENDER: Are you male?	Yes ☐	No ☐

Total Yes Responses: _____

3-4 = Moderate Risk for OSA, 5-8 = High Risk for OSA

EPWORTH SLEEPINESS SCALE:

Please indicate your chance of dozing off in the following situations using the following:

0- Would never doze
1- Slight chance of dozing
2- Moderate chance of dozing
3- High chance of dozing

Sitting and Reading	____	Laying down to rest in afternoon (when able)	____
Watching TV	____	Sitting and talking with someone	____
Sitting, inactive in public	____	Sitting quietly after lunch (w/o alcohol)	____
As a passenger in a car for an hour	____	In a car, stopped for a few minutes in traffic	____

Total: ____

0-6 Normal, 7-14 Mild Sleepiness, 15-17 Moderate Sleepiness, 18+ Severe Sleepiness

FOR OFFICE USE ONLY:

Patient meets the criteria for a comprehensive sleep evaluation and/or diagnostic sleep study. YES ☐ NO ☐

Patient Screening Form

ADA

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐Yes ☐ No	☐Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐Yes ☐ No	☐Yes ☐ No
Do you/they have a cough?	☐Yes ☐ No	☐Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐Yes ☐ No	☐Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐Yes ☐ No	☐Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients?*Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐Yes ☐ No	☐Yes ☐ No
Is your/their age over 60?	☐Yes ☐ No	☐Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐Yes ☐ No	☐Yes ☐ No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐Yes ☐ No	☐Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.