Welcome to our practice family! We are so excited you chose us for your dental care!

Our passion at Gilroy Family Dental Center/Lotus Dental Spa is to inspire you to smile, whether that is through relieving pain, prevention of dental problems, brightening your smile, or simply building relationship with our staff.

A smile is very powerful, and a healthy smile is even more valuable to your overall well-being. We are eager to make you feel comfortable, informed, and appreciated.

We believe in prevention and early diagnosis. As a part of taking care of our patient's oral health we like to put you on continuing care system.

It is recommended you get your mouth checked and your teeth cleaned every 6 months and most insurances cover these services.

During your recall visit we not only clean your teeth but we also do an exam of your mouth and teeth and we can diagnose any problem you may have early and can be an easy fix and less painful and less expensive, as compared when you visit when you have pain. To accomplish that we send you a postcard 2 weeks prior to your recall date. We will also put an effort to call or text you at least 3 times to remind you to schedule your appointment. Your prompt reply will help us to keep you on track to have a healthy and beautiful smile.

Please fill out all forms attached and bring with you to your first appointment. We encourage you to contact us if you have any questions prior to your appointment. We are looking forward to meeting you as well as taking care of your dental needs!

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions- please ask us- we will be happy to help!

KUSUM ATRAYA D.D.S

Diplomate, The American Board of Dental Sleep Medicine

Gilroy Family Dental Center
1395 1st St. Ste. 102 Gilroy, CA.95023
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support@lotusdentalspa.com

Lotus Dental Spa
18181 Butterfield Blvd., Ste 110
Morgan Hill, CA. 95037
Phone # (408)778-7700
Fax # (408) 778-7707

PATIENT INFORMATION:

First Name:_____ Last Name:_____ Middle Initial:_____
Address:_____City:_____ State:_____Zip code:_____
Home Phone:_____ Cell Phone:_____ Best time to call:_____
Birthdate:_____ Social Security #:_____Email:_____
Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated
Employer: _____Occupation:_____
Referred By: ☐ Family/ Friend:_____ ☐ Google ☐ Yelp ☐ Insurance Company
☐ Other:_____ Previous Dentist:_____
Emergency Contact: _____ Relationship: _____
Emergency Contact Phone Number #: _____ Preferred Pharmacy: _____

RESPONSIBLE PARTY: Patient is: ☐ Responsible Party
First Name:_____ Last Name:_____ Middle Initial:_____
Relationship to Patient: _____
Address:_____City:_____ State:_____ Zip code:_____
Home Phone:_____ Cell Phone:_____ Best time to call:_____
Birthdate:_____ Social Security #:_____Email:_____
Employer: _____Occupation: _____

PRIMARY INSURANCE:

Dental Insurance Company: _____
ID #/ Member ID: _____
Policy Holder Name: _____
Policy Holder DOB: _____
Policy Holder's SSN: _____
Policy Holder's Employer: _____

MEDICAL INSURANCE:

Medical Insurance Company: _____
ID#/ Member ID: _____
Policy Holder Name: _____
Policy Holder DOB:_____
Policy Holder's SSN: _____
Policy Holder's Employer: _____

I give my consent to Gilroy Family Dental Center to notify/ contact me via phone, email or text which may include personal health information. (example: Treatment plan, appt reminders, insurance verification/coverage). I agree that calls may be recorded for quality assurance & other reasons. I agree to have my photograph taken and stored in medical records.

Signature: _____ Date: _____

MEDICAL HISTORY:

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

If you answer yes to the following questions, please explain on the blank provided.	YES	NO
Are you under a physician's care now? _____	☐	☐
Have you ever been hospitalized or had a major operation? _____	☐	☐
Have you ever had a serious head or neck injury? _____	☐	☐
Are you taking any medications, pills, or drugs? _____	☐	☐
If yes, please provide a MEDICATIONS LIST: _____		
Do you take, or have taken Phen- Fen or Redux? _____	☐	☐
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	☐	☐
If yes please explain: _____		
Are you on a special diet? _____	☐	☐
Do you use tobacco? _____	☐	☐
Do you use controlled substances? _____	☐	☐

*Woman, are you: (Circle all that apply) Pregnant / Trying to get pregnant / Taking oral contraceptives / Nursing

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Other

If yes, please explain: _____

Do you have, or have you had, any of the following?

	YES	NO		YES	NO		YES	NO
AIDS/HIV Positive	☐	☐	Epilepsy	☐	☐	Leukemia	☐	☐
Alzheimer's Disease	☐	☐	Excessive Bleeding	☐	☐	Liver Disease	☐	☐
Anaphylaxis	☐	☐	Fainting Spells	☐	☐	Osteoporosis	☐	☐
Anemia	☐	☐	Frequent Cough	☐	☐	Psychiatric Care	☐	☐
Angina	☐	☐	Frequent Diarrhea	☐	☐	Radiation Treatments	☐	☐
Arthritis	☐	☐	Migraines	☐	☐	Renal Dialysis	☐	☐
Artificial Heart Valve	☐	☐	Genital Herpes	☐	☐	Rheumatism	☐	☐
Artificial Joint/s	☐	☐	Glaucoma	☐	☐	Scarlet Fever	☐	☐
Asthma	☐	☐	Hay Fever	☐	☐	Shingles	☐	☐
Blood Disease	☐	☐	Heart Attack	☐	☐	Sinus Trouble	☐	☐
Blood Transfusion	☐	☐	Heart Murmur	☐	☐	Spina Bifida	☐	☐
Breathing Problem	☐	☐	Heart Pacemaker	☐	☐	Stroke	☐	☐
Bruise easily	☐	☐	Heart Disease	☐	☐	Swelling of Limbs	☐	☐
Cancer	☐	☐	Hemophilia	☐	☐	Thyroid	☐	☐
Chemotherapy	☐	☐	Hepatitis A	☐	☐	Tonsillitis	☐	☐
Chest Pains	☐	☐	Hepatitis B or C	☐	☐	Tuberculosis	☐	☐
Cold Sores/ Fever Blisters	☐	☐	Heart Disease	☐	☐	Tumors	☐	☐
Congenital/ Heart Disorder	☐	☐	Herpes	☐	☐	Ulcers	☐	☐
Convulsions	☐	☐	High Blood Pressure	☐	☐	Venereal Disease	☐	☐
Cortisone Medicine	☐	☐	High Cholesterol	☐	☐	Yellow Jaundice	☐	☐
Diabetes	☐	☐	Hives/Rash	☐	☐	Other: _____		
Drug Addiction	☐	☐	Hypoglycemia	☐	☐	_____		
Emphysema	☐	☐	Kidney Problems	☐	☐			

To the best of my knowledge, the questions on this form have been accurately answered. I understand that not providing information can be dangerous to my or the patient's health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature of Patient/ Parent, or Guardian _____ Date _____

DENTAL HISTORY:

How would you rate the condition of your mouth? EXCELLENT GOOD FAIR POOR
Previous Dentist: _____ How long have you been a patient? _____
Date of most recent exam? _____ Date of most recent x-rays? _____
Date of most recent treatment (other than a cleaning): _____
I routinely see the dentist every: 3 months 4 months 6 months 12 months Not Routinely
What Is your immediate concern? _____

Please answer yes or no to the following:

PERSONAL HISTORY	YES	NO
1. Are your fearful of dental treatment? How fearful on a scale of 1 (least) to 10 (most)? _____	☐	☐
2. Have you had and unfavorable dental experience? _____	☐	☐
3. Have you had complications from past dental treatments? _____	☐	☐
4. Have you had trouble getting numb or had any reactions to local anesthetic? _____	☐	☐
5. Did you ever have braces, orthodontic treatment or have your bit adjusted? _____	☐	☐
6. Have you had any teeth removed? _____	☐	☐

SMILE CHARACTERISTICS		
1.Is there anything about the appearance of your teeth you would like to change? _____	☐	☐
2. Have you ever whitened (bleached) your teeth? _____	☐	☐
3. Have you felt uncomfortable or self- conscious about the appearance of your teeth? _____	☐	☐
4. Have you been disappointed with the appearance of previous dental work? _____	☐	☐

BITE & JAW POINT		
1.Do you have problems with your jaw point? (pain, sounds, limited opening, lock popping) _____	☐	☐
2. Do you/would you have any problems chewing gum? _____	☐	☐
3. Do you/would you have problems chewing bagels, protein bars or any other hard foods? _____	☐	☐
4. Have your teeth changed in the last 5 years, become shorter, thinner, or worn? _____	☐	☐
5. Are your teeth crowding or developing spaces? _____	☐	☐
6. Do you have more than one bite and squeeze to make your teeth fit together? _____	☐	☐
7. Do you chew ice, bite your nails, or use your teeth to hold objects or have any other oral habits? _____	☐	☐
8. Do you clench your teeth in the daytime, or do they become sore? _____	☐	☐
9. Do you have any problems with sleep or wake up with an awareness of y our teeth? _____	☐	☐
10. Do you wear, or have you ever worn a bite appliance? _____	☐	☐

TOOTH STRUCTURE		
1.Have you had any cavities within the past 3 years? _____	☐	☐
2. Does the amount of saliva in your mouth seem to little or have difficulty swallowing food? _____	☐	☐
3. Do you feel or notice any holes on the biting surface of your teeth (i.e. pitting, craters)? _____	☐	☐
4. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? ____	☐	☐
5. Do you have any grooves or notches on your teeth near the gum line? _____	☐	☐
6. Have you ever had broken teeth, chipped teeth or had a toothache, or a cracked filling? _____	☐	☐
7. Do you frequently get food caught between any teeth? _____	☐	☐

BIOLOGY		
1.Do your gums bleed or are they painful when bruising or flossing? _____	☐	☐
2. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____	☐	☐
3. Have you ever noticed an unpleasant odor from your mouth? _____	☐	☐
4. Is there anyone with a history of periodontal disease in your family? _____	☐	☐
5. Have you ever noticed gum recession? _____	☐	☐
6. Have you ever had any teeth become loose on their own (NO INJURY) or have difficulty eating an apple?	☐	☐

SUMMARY OF FINANCIAL POLICIES:

Will my insurance cover this visit?
In most cases, yes, but every procedure is different. Gilroy Family Dental Center is in network with many different PPO plans. We do not accept Medi-Cal. We do our best to help you know before you come in if your insurance will cover a visit from us. It is, however, ultimately your responsibility to know your plan, whether your insurance is current and active (you will be asked) and to check with your carrier first to make sure we will be considered in-network for your visit. As a courtesy to you, we will help process all your insurance claims. For our practice to file your insurance claim you must provide proof of insurance either with a card or information provided to the office when setting up the appointment.

Initials: _____

How much will this visit cost me?
Short answer: we don't know the exact amount, every patient and each plan is different. However, a treatment plan will always be given to you with a **ROUGH ESTIMATE** of your responsibility for your treatment, with or without insurance. If you have insurance you may have a co-pay, coinsurance and/ or deductible. ***Your insurance has the final word. All charges you incur are your responsibility regardless of your insurance coverage.***

Initials: _____

How and when do I pay?
Our policy is: **Payment Due at Time of Service"** Your estimated co-payment for treatment, which is the amount not covered by insurance, is due at the time treatment is provided. Your estimated co-payment may be adjusted after the time of treatment depending on the final reconciliation of insurance payments. If you do not have insurance, we expect full payment for service at each office visit.

Initials: _____

Do you offer payment plans?
Yes, we offer o% interest payment plans. The most important thing is that you call and speak to our billing specialist to arrange a plan as soon as you are aware that you need some assistance in managing the payment. The card that is kept on file with our office will be used to collect the agreed upon amounts at the agreed upon dates.
We do offer third-party financing through CareCredit, if your portion is over $500.00

Initials: _____

Do you send patients patients to collections?
Yes, unfortunately. Any balances that remain unpaid for more than 90 days from a final determination by your insurance as to the correct charges will be sent to collections.

Initials: _____

Is there a fee for a late cancellation or not showing up for a scheduled appointment?
YES, there is. A "no show" is defined as a patient who fails to reschedule more than 24 hours before their scheduled visit. For Monday appointments this means by the prior Thursday by 5pm (one business day) If you call our office more than 24 hours before your visit to let us know you cannot make it there is no charge. **The fee for "No Show" is $50.00.** We really dislike having to do this, but we really do need enough notice to allow other patients to be able to be put on the schedule. We value your time and we request for you to value our time as well; we do one patient at a time and we try our best to be always on time. We reserve your time with Dr, Atraya exclusively to you, so she can give her 100% attention to you and your needs. If by any chance due to unforeseen circumstances, Dr. Atraya is running behind schedule we will inform you beforehand. (It doesn't happen very often.) A lot of preparation goes into planning your appointment and speaking with your insurance. We do understand that extenuating circumstances can arise, and we're open to discuss those on a case by case basis.

Initials: _____

CONSENT FOR SERVICES AND ACKNOLEDGMENT OF PRIVACY PRACTICES

I authorize the undersigned provider and any other qualified assistants and medical professionals to perform the medical/dental procedures and needed treatments. I also give my consent to these individuals to administer any needed medicine and to perform any compulsory lifesaving procedures. I understand that this office recognizes HIPPA Privacy Practices and a copy of this notice was made available to me.

Signature: _____ Date: _____

I understand the risks inherent in the treatment(s). I have discussed the risks and the treatment plan, all the questions and concerns I have presented have been answered. I understand that the expected results of the procedures or the course of the treatment. I understand that these results cannot be guaranteed and may not be achieved. I am aware of my right to waive treatment of any kind, and I am aware of the possible consequences of non-treatment. I understand my dental condition and have discussed several procedure options with the procedures, and I have been given a copy of treatment details.

I confirm and understand the forms and the information. I am a native speaker of English or have been offered the services of a translator who explained the information in my native language.

This agreement is to inform you of your financial obligation to our practice. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

Sleep Disorder Assessment Form

This form will help us to evaluate if you need to have an at-home sleep test. The test will help us determine if you have a sleep disorder. Sleep disorders negatively affect your well-being, especially your cardiovascular health and immune system. However, sleep disorders can be treated easily and effectively.

Name:	**Date of Birth:**	**Height:**
Phone #:	**Gender:**	**Weight:**
E-mail:		**Neck Size:**
Address:		**City/State:**

CPAP Compliance:

1. Have you ever been given a CPAP device? : □ Yes □ No
2. If yes, do you use it every night? : □ Yes □ No
3. If yes, how many hours per night? :
4. Are you comfortable/satisfied with your CPAP ?: □ Yes □ No

1. Epworth Sleep Scale:

On a scale from 0 to 3 please rank the likelihood you would doze off in each scenario.

(0 = no chance, 1 = slight chance, 2 = moderate chance, 3 = high chance)

1. Being a passenger in a motor vehicle for an hour or more 0 1 2 3
2. Sitting and talking to someone 0 1 2 3
3. Sitting and reading 0 1 2 3
4. Watching TV 0 1 2 3
5. Sitting inactive in a public place 0 1 2 3
6. Lying down to rest in the afternoon 0 1 2 3
7. Sitting quietly after lunch without alcohol 0 1 2 3
8. In a car, while stopped for a few minutes in traffic 0 1 2 3

Total:

____

2. STOPBANG Questionnaire (Circle Y or N):

Do you snore loudly(loud enough to be heard through closed doors or your bed partner elbows you for snoring at night) ?	Yes	No
Do you often feel tired, fatigued, or sleepy during the daytime?	Yes	No
Has anyone observed you stop breathing or choking/gasping during your sleep?	Yes	No
Do you have or are being treated for high blood pressure?	Yes	No
Body mass index higher than 35 kg/m^2 ?	Yes	No
Age older than 50 years?	Yes	No
Neck size large? (Men: 17 inches +, Women: 16 inches +)	Yes	No
Sex = male?	Yes	No

3. Have you been diagnosed or treated for any of the following conditions? (Circle Y or N):

Diabetes	Y	N	Coronary Heart Disease	Y	N	Morning Headaches	Y	N
Acid Reflux	Y	N	Irregular Heart Rhythm	Y	N	Depression	Y	N
Sleep Apnea	Y	N	Congestive Heart Failure	Y	N	Obesity	Y	N
Stroke	Y	N	Atrial Fibrillation	Y	N	Restless Legs	Y	N
Mental Confusion	Y	N	Erectile Dysfunction	Y	N	Insomnia	Y	N
Memory Loss	Y	N	Weak Immune System	Y	N	Liver Disease	Y	N

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____