Matthieu Sullivan, DDS
8540 S Sepulveda Blvd, Ste 800
Los Angeles, CA 90045
(310) 670-1200

PATIENT INFORMATION

(This information is necessary for our files and will be considered **CONFIDENTIAL**)

Patient's Full Name _____ Age _____ Birthday _____ Date _____
Preferred Name _____ ☐ Male ☐ Female ☐ _____
If patient is a minor, give name of parent or legal guardian _____ Relationship _____
Residence Address _____ For how long? _____ ☐ Own ☐ Rent
Home Phone (____)_____ Cell Phone (____)_____ Work Phone (____)_____
E-mail _____ Social Security No. _____
Patient is: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Minor
Occupation _____ Employer _____ How long? _____
Business Address _____ Business Phone (____)_____
Spouse's Name _____ Social Security No. _____
Occupation _____ Employer _____ How long? _____
Emergency Contact _____ Relationship _____ Phone (____)_____
Physician _____ Phone (____)_____ ☐ I have no physician
Former Dentist _____ Phone (____)_____
Why are you changing dentists? _____ Do you wish to speak to the
Purpose of Appointment _____ Doctor privately? ☐ Yes ☐ No
Is this office visit for Emergency Dental Care? ☐ Yes ☐ No If yes, explain: _____
Whom may we thank for referring you? _____

FINANCIAL INFORMATION

Person responsible for this account _____ Relationship _____ Phone (____)_____
Address _____ Email _____
Insurance Company (Primary) _____
Insured Person _____ Birthdate _____ Relationship _____ Soc. Sec. No. _____
Group Dental Plan _____ Group No. _____ Plan No. _____ Name of Union _____
Insurance Company (Secondary) _____
Insured Person _____ Birthdate _____ Relationship _____ Soc. Sec. No. _____
Group Dental Plan _____ Group No. _____ Plan No. _____ Name of Union _____

TERMS & CONDITIONS

As a condition of treatment by this office, I understand 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 service performed without prior financial arrangements, must be paid for in cash at the time services are performed.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy.

A service charge of 1.5% per month (18% per annum) (but in no event more than the maximum rate permissible understate law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination.

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or their staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or their 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 billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's and/or collection fees.

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

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

Signature _____ Date _____

HEALTH QUESTIONAIRE

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.

MEDICAL HISOTRY

1. Are you in good health? ..... ☐Yes ☐No
2. What is the date of your last physical examination? _____
3. Are you now under the care of a physician? ..... ☐Yes ☐No
   If so, what is the condition being treated? _____
4. Have you ever had any serious illness or operation? ..... ☐Yes ☐No
   If so, what illness or operation? _____
5. Have you ever been hospitalized? ..... ☐Yes ☐No
   If so, what was the problem? _____
6. Are you taking any ☐ medications, ☐ drugs, ☐ herbs, ☐ blood thinners? ..... ☐Yes ☐No
   If so, what and at what dosage? _____
7. Are you using any recreational drugs? ☐ Yes ☐ No If so, what? _____
8. Have you ever been pre-medicated with antibiotics for your dental treatment? ..... ☐Yes ☐No
9. Are you sensitive or allergic to any drugs or materials? ..... ☐Yes ☐No
   ☐ Penicillin ☐ Tetracycline ☐ Sulfa Drugs ☐ Aspirin ☐ Codeine ☐ Latex ☐ Other _____
10. Do you have or have you had any of the following: (Please mark '**Y**' for Yes or '**N**' for No – answer all conditions)

Y N Heart Ailment	**Y N** Blood Disease	**Y N** Asthma	**Y N** Cortisone Medicine	**Y N** Cancer	**Y N** Chicken Pox
Y N High Blood Pressure	**Y N** Sickle Cell Anemia	**Y N** Liver Disease	**Y N** Headaches	**Y N** Chemotherapy	**Y N** HIV or AIDS
Y N Low Blood Pressure	**Y N** Excessive Bleeding	**Y N** Hepatitis/ Jaundice	**Y N** Head Injuries	**Y N** Radiation Therapy	**Y N** Herpes
Y N Heart Defect	**Y N** Bruise Easily	**Y N** Kidney Disease	**Y N** Fainting Spells	**Y N** Joint Replacement	**Y N** Venereal Disease
Y N Angina Pectoris	**Y N** Hemophilia	**Y N** GI Ailment	**Y N** Seizures	**Y N** Artificial Prosthesis	**Y N** Drug Addiction
Y N Heart Attack	**Y N** Anemia	**Y N** Ulcers	**Y N** Epilepsy	**Y N** Osteoporosis	**Y N** Implant(s)
Y N Heart Murmur	**Y N** Blood Transfusion	**Y N** Diabetes	**Y N** Cerebral Palsy	**Y N** Glaucoma	**Y N** Sinus Trouble
Y N Heart Failure	**Y N** Stroke	**Y N** Low Blood Sugar	**Y N** Tumor or Growth	**Y N** Tonsilitis	**Y N** Snoring
Y N Mitral Valve Prolapse	**Y N** Lung Disease	**Y N** Thyroid Disease	**Y N** Nervous Disorder	**Y N** Cold Sores	**Y N** Sleep Apnea
Y N Scarlet Fever	**Y N** Emphysema	**Y N** Arthritis	**Y N** Mental Disorder	**Y N** Allergies or Hives	**Y N** Pain in Jaw Joints
Y N Rheumatic Fever	**Y N** Tuberculosis (T.B.)	**Y N** Rheumatism	**Y N** Psychiatric Care	**Y N** Hay Fever	**Y N** Difficulty Swallowing

11. Do you have any disease, condition, or problem not listed? ..... ☐Yes ☐No
    If so, what? _____
12. Do you wear a cardiac pacemaker, or have you had heart surgery? ..... ☐Yes ☐No
13. Do you smoke? ..... ☐Yes ☐No
14. Have you ever taken ☐Diet Drugs (Fen-Phen/Redux) ☐ Bisphosphonates (Fosamax, Zometa, Actonel, Boniva, Aredia) ? ☐Yes ☐No
15. (Women) Are you pregnant? If so, how many months? _____ ☐Yes ☐No
16. (Women) Do you have any problems associate with your menstrual cycle? ..... ☐Yes ☐No
17. (Women) Do you take any birth control medication or hormones? ..... ☐Yes ☐No

DENTAL HISTORY

1. Have you ever had any unfavorable reaction to a local anesthetic (Novocaine, Lidocaine, etc)? ..... ☐Yes ☐No
2. Have you had any serious trouble associated with any previous dental treatment? ..... ☐Yes ☐No
   If so, explain: _____
3. How long since your last set of dental radiographs (x-rays)? _____ Weeks _____ Months _____ Years
4. How long since your last dental treatment? _____ Weeks _____ Months _____ Years
5. Does dental treatment make you nervous? ☐ Slightly ☐ Moderately ☐ Extremely ..... ☐Yes ☐No

☐ I hereby acknowledge I have received a copy of this practice's **Notice of Privacy Practices**. I further understand that the practice will offer me updates to this Notice of Privacy Practices should it be amended, modified, or changes in any way.
☐ Patient refused / was unable to sign because _____.

☐ I have received a copy of the **Dental Materials Fact Sheet** as required by law.

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

Signature _____ Date _____

DO NOT WRITE IN THIS SPACE Blood Pressure _____ / _____ Heart Rate _____
Reviewed by _____ License # _____ Date _____

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

All services are rendered and accepted under the terms and conditions printed on the reverse hearof: Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Signature _____ Date _____ Relationship to Patient _____

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General Dentistry Consent Form

Name: _____ Date: _____

I understand I am having the following treatment:
FILLINGS ( ), BRIDGES ( ), CROWNS ( ), EXTRACTIONS ( ), ROOT CANALS ( ), _____ ( )

INITIALS:

_____ Drugs and Medications:
I understand that antibiotics, analgesics, and other medication can cause allergic reactions causing redness, swelling of the soft tissue, pain, vomiting, and/or anaphylactic shock (severe allergic reaction).

_____ Changes in Treatment Plan:
I understand that during treatment it may be necessary to change or add procedures due to the condition found while working on the teeth that were not discovered during the exam. The most common are root canal therapy following a restorative procedure such as a filling or crown. I give consent to the treating dentist to make all changes necessary.

_____ Removal of Teeth:
I understand that I am having a tooth extracted. All applicable alternative treatments have been explained to me. I understand that removing a tooth does not mean "removing the infection" and further treatment may be necessary. I understand risks include dry socket, infection, swelling, and numbness. Paresthesia can last an indefinite period of time. I understand that such complications can sometimes cause hospitalization and incur costs at my expense.

_____ Crown and Bridge ("Caps"):
I understand that I am having a crown made to restore a tooth, which requires reducing the natural tooth. I understand that sometimes it is not possible to match the crown material to the exact color of natural teeth. I understand that I can make final changes to color, fit, and shape before the crown is cemented permanently. I understand that I must return to my scheduled appointment for the delivery of my crown or bridge; and neglecting that visit can compromise the proper fit of the restoration, and I will be responsible for any lab fees incurred if a remake becomes necessary.

_____ Full Denture or Partial Denture:
I understand that a full or partial denture is artificial and constructed of plastic, metal, and/or resin. It has been explained to me that wearing these appliances can cause soreness of the soft tissue, loseness, or breakage of teeth. I understand that any changes can be made at the "try in wax visit." I understand that a laboratory and.or chair side reline may be necessary in the future and would necessitate a separate fee.

_____ Endodontic Treatment (Root Canal):
I understand that a root canal therapy has been diagnosed to treat my tooth. I understand that there is no guarantee of long/ good prognosis. Some complications can occur, such as infection, inflammation, and/or pain. Root canal filling can extend through the root or not reach the apex (tip of the root). Occasionally, surgical procedures may be needed following a root canals, such as apicoectomy or extraction.

_____ Periodontal Treatment:
I have been advised of my advanced periodontal condition. My dentist has advised me to see a Periodontist. Neglecting such recommendations may have an adverse effect and lead to severe bone loss and/or loss of some or all my teeth.

I acknowledge that no guarantee of results has been made by Dr. Matthieu Sullivan, his Associates, or his staff regarding my dental treatment. By signing this consent I acknowledge that I have read, initialed, and signed this consent.

Patient Signature: _____ Date: _____

Doctor Signature: _____ Witness: _____

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Consent for Use and Disclosure of Health Information

Section A: Patient Given Consent
Name: _____

Section B: Please read the following statements carefully:

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

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. The Notice provides a description of our treatment, payment activities, and health operations, of the uses and disclosures we may make of your protected health information, and of other important materials about 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 of your protected health information that we maintain.

No mobile opt-in message consent will be shared with third parties or affiliates for marketing purposes.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

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Los Angeles, CA 90045
Phone: (310) 670-1200
Fax: (310) 670-5352

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

Signature

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices, I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Patient Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

REVOCATION OF CONSENT
I revoke my Consent for your use and disclosure of my protected health information for treatment, payment, and health operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you receive this written notification of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

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Written Financial Policy

Thank you for choosing Matthieu Sullivan, DDS. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options

You can choose from:

-Cash, Check Visa or Mastercard:
We offer a *3%* courtesy accounting adjustment to patients who pay for their treatment with cash prior to the completion of care

-Convenient Monthly Payment Plans from CareCredit, Cherry, or Sunbit

- Allow you to pay over time
- No annual fees or pre-payment penalties

Please note:

Matthieu Sullivan, DDS requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For plans requiring multiple appointments, alternative payment arrangements may be provided.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.

A fee of $50 is charged for patients who miss or cancel more than 1 time in a calendar year without 24-hour notice.

Matthieu Sullivan, DDS charges $50 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient Signature: _____ Date:_____

Print Name: _____

Subject to Credit Approval

However, if we do not receive payment from your insurance carrier within 60 days you will be responsible for the full amount of treatment fees and the collection of your benefits directly from your insurance carrier.

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Smile Evaluation

Hold a full face mirror 12"-14" from your face. Smile to show your teeth; take time to observe your teeth carefully. Then answer the following questions.

1. Do you like the appearance of your teeth and your smile? YES NO
   If not, explain _____
   _____

2. Are your teeth all in alignment (straight)? YES NO
   If not, explain _____
   _____

3. Are any teeth… CHIPPED PROTRUDING HIDDEN

4. Do you have spaces that you don't like? YES NO
   If not, explain _____
   _____

5. Do you like the color of your teeth? YES NO
   If not, explain _____
   _____

6. Do you like the shape of your teeth? YES NO
   If not, explain _____
   _____

7. Do you like the way your teeth come together? YES NO
   If not, explain _____
   _____

8. Are there any old fillings or dental work that you don't like looking at? YES NO
   If not, explain _____
   _____

9. What would you like to change the most in the appearance of your teeth?
   _____
   _____

10. How would you like your teeth to look?
    _____
    _____