



# *In Motion Dentists*

In Home Dental Care

---

Welcome to our practice,

Thank you for choosing *In Motion Dentists* to serve you or your loved one's dental needs. At *In Motion Dentists*, we strive to make your experience unforgettable in a positive way. We understand that it may have been several years since you've been to a dentist or that your dental health may not be as good as it used to and, we completely understand. Our main goal is to take care of you or your loved one's dental needs and keep them comfortable in the process.

At *In Motion Dentists*, we provide comprehensive portable dental services in the comfort of your home. This includes, x-rays, fillings, crowns, extractions, dentures and more. We have found that arranging the transportation to get to the dentist can be the biggest hurdle to getting the needed dental services one requires, and for some, it's next to impossible.

**At your initial visit**, the dentist first reviews your medical history and discusses your desires to improve your dental health. This is the most important part of the exam. Treating one safely requires a knowledgeable and experienced dentist who works with people just like you day-in and day-out. You will receive a comprehensive exam and, if required, dental x-rays and photographs. At this initial visit you will be provide with the information you need to make a decision on what dental treatment is best for you or your loved one based on several factors including current health status and the patients' dental needs/desires. Before leaving we will strive to answer all your questions and concerns as thoroughly as possible.

Dr. Banner and his staff at *In Motion Dentists* look forward to meeting you during your consultation in your home. We promise to provide you or your loved one with the highest quality of dental care that they would receive in a traditional dental practice setting. The patient's health and safety is always our highest priority.

If you haven't already, please take some time to learn about our practice on our website:  
[InMotionDentists.com](http://InMotionDentists.com)

At the initial visits, please have the following ready for the dentist:

1. Completed attached forms
2. If available, the patients dental benefits card (As a reminder, we assist you in submitting your dental claim. However, you are responsible for your account and payment is due when services are rendered).

Please do not hesitate to contact us should you have any questions or concerns.

Sincerely,

In Motion Dentists



# In Motion Dentists

In Home Dental Care

## PATIENT CONTACT INFORMATION

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex: M / F  
 Patient's address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 Home #: \_\_\_\_\_ Cell#: \_\_\_\_\_ Email: \_\_\_\_\_  
 Parent/Guardian/POA Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 Home #: \_\_\_\_\_ Cell#: \_\_\_\_\_ Email: \_\_\_\_\_  
 Name of primary caretaker: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Who may we thank for referring you to our practice? \_\_\_\_\_

## DENTAL INSURANCE INFORMATION

Dental Carrier: \_\_\_\_\_ Insured Name: \_\_\_\_\_  
 Group #: \_\_\_\_\_ Date of Birth (of insured): \_\_\_\_\_  
 ID/SSN# (of insured): \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

## DENTAL HISTORY

1. What is the reason for your visit today? \_\_\_\_\_
2. Are you inquiring about having all dental care done under General Anesthesia or IV Sedation? Yes No
3. What was the date of your last dental visit: \_\_\_ / \_\_\_ / \_\_\_ Dental cleaning: \_\_\_ / \_\_\_ / \_\_\_ X-rays: \_\_\_ / \_\_\_ / \_\_\_
4. Have you ever been treated for periodontal (gum) disease? Yes No
5. Have you ever had orthodontic therapy or worn braces? Yes No
6. Are you aware of clenching or grinding your teeth? Yes No
7. Do you have:
 

	Yes	No		Yes	No		Yes	No
Bleeding, sore gums:	<input type="checkbox"/>	<input type="checkbox"/>	Loose teeth:	<input type="checkbox"/>	<input type="checkbox"/>	Unpleasant breath:	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to sweets:	<input type="checkbox"/>	<input type="checkbox"/>	Shifting of teeth:	<input type="checkbox"/>	<input type="checkbox"/>	Burning tongue/lips:	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to biting:	<input type="checkbox"/>	<input type="checkbox"/>	Change in bite:	<input type="checkbox"/>	<input type="checkbox"/>	Clicking jaw:	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to hot/cold:	<input type="checkbox"/>	<input type="checkbox"/>	Food impaction:	<input type="checkbox"/>	<input type="checkbox"/>	Locking jaw:	<input type="checkbox"/>	<input type="checkbox"/>
8. How often do you:
 

Brush	_____ x's/day	<input type="checkbox"/> Assisted	<input type="checkbox"/> Unassisted
Floss	_____ x's/day	<input type="checkbox"/> Assisted	<input type="checkbox"/> Unassisted
Mouthwash	_____ x's/day	<input type="checkbox"/> Assisted	<input type="checkbox"/> Unassisted
9. Do you use a standard or electric toothbrush?  Standard  Electric



# In Motion Dentists

## In Home Dental Care

### HEALTH HISTORY

1. Current primary care physician:

Physician Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

2. Other medical specialist seen within the last 2 years:

Name: \_\_\_\_\_ Phone#: \_\_\_\_\_ Specialty: \_\_\_\_\_

Name: \_\_\_\_\_ Phone#: \_\_\_\_\_ Specialty: \_\_\_\_\_

3. Are you currently taking any medications?  Yes  No

If yes, please list the name, dosage, & medical condition (or attach list of medications): \_\_\_\_\_

4. Have you ever had an allergic reaction to any medication or to latex?  Yes  No

If yes, please list medication & effects: \_\_\_\_\_

5. a. Have you ever taken Fenflouramine/Phentermine (FEN-PHEN) medications?  Yes  No

If yes, have you ever had an echocardiogram?  Yes  No

Date: \_\_\_\_\_ Results: \_\_\_\_\_

b. Are you taking anticoagulant medication? (Coumadin, Warfarin, Plavix, Ticlid, Heparin)  Yes  No

If yes, name of medication: \_\_\_\_\_

c. Are you taking or have you ever taken bisphosphonate drugs? (Actonel, Aredia, Boniva, Didronel, Fosamax, Reclast, Skelid, Zometa)  Yes  No

If yes, name of medication: \_\_\_\_\_ How long taken? \_\_\_\_\_

6. Women only: Are you pregnant?  Yes  No Nursing?  Yes  No Taking birth control pills?  Yes  No

7. Height: \_\_\_\_\_ Weight: \_\_\_\_\_

8. Do you smoke or use tobacco?  Yes  No

9. Please mark the best answer:

- a. Mobility:  Ambulatory  Walker  Wheelchair  Non-ambulatory
- b. Diet:  No restrictions  Soft Foods  Puree  Feeding Tube
- c. I live:  At home  In a Group Home  In a care facility  Other: \_\_\_\_\_

10. Do you have or have you ever had any of the following: (Please check all that apply)

	Yes	No		Yes	No		Yes	No		Yes	No
Alcohol/Drug Abuse:	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/Epilepsy:	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia:	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever:	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's/Dementia:	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes:	<input type="checkbox"/>	<input type="checkbox"/>	Herpes:	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care:	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatism/Arthritis:	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/Fainting:	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (A,B,C)	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea:	<input type="checkbox"/>	<input type="checkbox"/>
Anemia:	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema:	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure:	<input type="checkbox"/>	<input type="checkbox"/>	Stroke:	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints/Limbs:	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma:	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS:	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Asthma:	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack:	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease:	<input type="checkbox"/>	<input type="checkbox"/>	(Hypo/Hyper)		
Cancer, Tumors:	<input type="checkbox"/>	<input type="checkbox"/>	Headaches, Migraines:	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice:	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis:	<input type="checkbox"/>	<input type="checkbox"/>
Chemo/Radiation:	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery:	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease:	<input type="checkbox"/>	<input type="checkbox"/>	STDs:	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain:	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease:	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse:	<input type="checkbox"/>	<input type="checkbox"/>			
Blood Transfusion:	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur:	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker:	<input type="checkbox"/>	<input type="checkbox"/>			

11. Do you have or have you ever had any disease, condition or problem not on this list? \_\_\_\_\_

I understand that the information gathered on this medical history form is intended to help inform the In Motion Dentists' staff of any pre-existing medical conditions so that the best course of treatment can be determined. I understand that failure to disclose this information could affect my own safety. I affirm that the medical information indicated here is accurate and complete.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## FINANCIAL/INSURANCE POLICY

Welcome to *In Motion Dentists*! It is our commitment to provide you with the comprehensive and affordable dental treatment in the comfort of your home. It is our responsibility to keep you informed of treatment recommendations and financial obligations. The following is our office payment policy:

### **Payment for Services**

Payment is due at the time services are rendered, as *In Motion Dentists* is a fee for service practice. If the individual who is taking on the responsibility to pay for the patient's dental services is not able to be present at the time dental services will be provided, payment must be made before treatment can be scheduled or payment must be left with the patient (or their caregiver/administrator) to be paid at the time services are offered. After payment is made, a receipt will be sent to the payee in a timely manner.

We accept cash, debit cards, credit cards and personal checks.

### **If you have Insurance**

If you have dental insurance, we will be happy to complete and submit the claim form to the insurance in order for you to receive reimbursement. While the completion of the insurance claim form is a courtesy that we extend to our patients, all charges and payments are your responsibility on the date that services are rendered. Please keep in mind that your insurance plan is a contract between you and the insurance company and is in no way an obligation between that insurance company and *In Motion Dentists*. After we submit the claim form to your insurance, it is your responsibility to follow-up with your insurer for reimbursement. We encourage you to read and understand your dental policy.

### **Procedures for payment/reimbursement**

- Payment is due in full at the time services are rendered.
- As a courtesy to our patient, we will complete a dental claim form and mail it to your insurance for your reimbursement.
- You will mail the dental claim form to your dental insurance.
- Your insurance carrier will review your claim and make determination of your payment. Some services may not be covered by your plan, or your insurance carrier may pay only a portion of the charges. We cannot know these amounts in advance; therefore, payment is your responsibility.
- Our office does not guarantee that you will receive reimbursement from your insurance company. Please contact your insurance company for answers to specific questions regarding your coverage, their payment policies and reimbursement procedures. We recommend calling your insurance company to expedite claims if a claim has not been paid within 30 days.

### **Other fees**

Outstanding balances: Outstanding balances over 30 days will be assessed a \$25 fee per month until the patient's account balance is paid in full. This fee is to cover the administrative cost that is incurred while attempting the collect payment.

Should you have any questions regarding your financial responsibility, please contact the office; we are here to answer your questions. It is the purpose of this policy to eliminate any misunderstandings, and therefore, have more time to dedicate to your dental care.

I certify that I have read, understand, and received a copy of the above policy. I understand my financial responsibility for dental treatment.

Name of financially responsible party: \_\_\_\_\_

Relationship: \_\_\_\_\_

Signature of financially responsible party: \_\_\_\_\_

Date: \_\_\_\_\_

Patient, Guardian or Conservator Signature: \_\_\_\_\_

Date: \_\_\_\_\_



### CANCELLATION/MISSED/RESCHEDULED APPOINTMENTS

Thank you for choosing *In Motion Dentists* to take care of your dental needs. We strive to provide you with the best care possible. As a patient of our practice, we will always strive to treat you in a timely manner while providing you with the highest quality of care. Our portable practice is unique in dentistry and because of this, we must have additional policies that allow all patients to be treated timely and predictably. Our appointments are 1-2 hours long per patient. This makes the time we have in a given day very valuable to treat those that use our services. For this reason, the following policies have been put into place:

**Missed Appointments:** A missed appointment will result in a charge of 25% of the planned treatment based on our “usual and customary rate” (UCR). We encourage you to give us a call and speak with Lucy, the office manager, regarding the reason for missing your scheduled appointment.

**Canceled Appointments:** Due to the nature of our practice, it is often difficult to fill voids in our schedule last minute. For this reason, we require a 48-hour advanced notice for canceling your appointment. If appointments are cancelled less than 48 hours in advance, our “Missed Appointments” policy will be applied (See above).

**Rescheduled Appointments:** Again, because it is difficult to fill voids in our schedule last minute, a “Missed Appointments” charge will be applied if you reschedule less than 48 hours prior to your dental appointment. As a “Thank you” for rescheduling with us, we will apply 50% of the “Missed Appointment” charge towards your next appointment.

**Late to Your Appointment:** We strive to be at your house within 15 minutes of the scheduled time. Travel time, equipment set-up and clean-up are built into appointments. Our doctors will wait up to 20 minutes past the scheduled appointment time. If you are not home for your appointment, we will make every effort to get ahold of you to verify if you are running late. If we cannot get ahold of you within 20 minutes, this will be considered a missed appointment and the “Missed Appointments” policy will be applied. If we do get ahold of you and you let us know that you are going to be more than 20 minutes late, one of 2 things will occur:

1. If you were scheduled for a 1 hour appointment, the appointment will be re-scheduled for another day. In this case, our “Rescheduled Appointments” policy will be applied (See above). If you choose not to reschedule your appointment, our “Missed Appointments” policy will be applied.
2. If you were scheduled for longer than a 1 hour appointment, it is possible (not guaranteed) our doctors will still be able to complete some treatment. If our doctors determine they are unable to perform all scheduled work for that day, a \$50 late fee will be applied to your visit total. If all the scheduled work is still able to be completed, no fee will be applied. If our doctors determine they do not have the time to begin your treatment while keeping the quality of dental care at the highest level of treatment, your appointment will need to be rescheduled. In this case, our “Rescheduled Appointments” policy will be applied (See above). If you choose not to reschedule your appointment, our “Missed Appointments” policy will be applied.

We acknowledge that we occasionally run behind schedule. We apologize in advance for the inconvenience and ask for your understanding that dental emergencies occasionally create delays in our schedule. Please let us know if you have any questions about this policy. We appreciate your cooperation in this matter.

I certify that I have read, understand, and received a copy of the above policy.  
I understand my financial responsibility for dental treatment.

Name of financially responsible party: \_\_\_\_\_

Relationship: \_\_\_\_\_

Signature of financially responsible party: \_\_\_\_\_

Date: \_\_\_\_\_

Patient, Guardian or Conservator Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**\*You May Refuse to Sign This Acknowledgement\***

I, \_\_\_\_\_ (Patient/Guardian/POA) have received a copy of this office's Notice of Privacy Practices.

Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**FOR OFFICE USE ONLY**

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

\_\_\_ Individual refused to sign

\_\_\_ Communications barrier prohibited obtaining the acknowledgement

\_\_\_ An emergency situation prevented us from obtaining acknowledgement

\_\_\_ Other (Please Specify): \_\_\_\_\_



# In Motion Dentists

## In Home Dental Care

### NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

#### OUR LEGAL DUTY

We are required by federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights to protect your health information. We are required to follow the privacy practices that are described in this notice while it is in effect. This notice takes effect May 1, 2017, and will remain in effect until we replace it. We reserve the right to change our privacy practice and the terms of this notice at any time, provided such changes are permitted by law. We reserve the right to make the changes in our privacy practice and the new terms of our notice effective for a health information that we maintain, including health information we created or received before we made the changes. When making a significant change in our privacy practice, we will change this notice and will make the new notice available upon request. You may request a copy of our notice at any time. If you give us authorization, you may revoke it at any time in writing. Your revocation will not affect any use or disclosure permitted by your authorization while it is in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

#### USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for the following purposes:

**Treatment:** We may use or disclose your health information to another dentist, or health care provider providing you with treatment that we do not or cannot provide.

**Payment:** We may use and disclose your health information to obtain payment for services we provided to you for example, your dental health plan/insurance. Unless you request that we restrict such disclosure to your health plan/insurance when you have paid out of pocket and in full for the services rendered.

**Healthcare operations:** We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioners and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**To you, your family, friends, or personal representative:** We must disclose your health information to you, as described in the Patient's Rights section of this notice. With your consent, we may disclose your health information to your family, friends or personal representative.

**Marketing Health Related Services:** We will not use or disclose your health information for marketing purposes without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Public Health:** We may use or disclose your health information to public health agencies such as the Food and Drug Administration (FDA) for purposes related to preventing the spread of disease, vital statistics, and to alert someone who may be at risk of contracting or spreading a disease. We may also use or disclose your health information to report abuse, neglect, domestic violence, to avert a serious threat to health or safety; and to comply with worker's compensation or similar programs.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

**Appointment Reminders:** We may contact you to provide you with appointment reminders via voicemail, postcards, or letters. We may also leave a message with the person answering the phone if you are not available.

#### PATIENT RIGHTS

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so and we will provide that to you in a timely manner.

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclose your health information for purposes other than treatment, payment, healthcare operations, and certain other activities.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances such as an emergency, for public health activities, or when required by law). In the event you pay out of pocket and in full for services rendered, you may request that we do not share information regarding your health with your health plan/insurance.

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means for example via email or text.

**Amendment:** You have the right to request that we amend your health information. Your request should be in writing and must state the reason why the information should be amended. We may deny your request under certain circumstances.

**Breach Notification:** In the event your unsecured protected health information is breached, we will notify you as required by law. In some situations, you may be notified by our business associates.

#### QUESTIONS AND COMPLAINTS

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or have us communicate with you by alternative means or alternative locations, you may complain to us using the information listed at the end of this notice. You also have the right to submit your complaint to the U.S. Department of Health and Human Services, Office of Civil Rights, which we can provide upon request.

If you want more information about our privacy practices or have questions or concerns, please contact us at:

**In Motion Dentists**  
2060 E. Route 66 #105  
Glendora, CA 91740  
Tel. (626) 594-0374  
Fax: (626) 594-0813

Email: [office@InMotionDentists.com](mailto:office@InMotionDentists.com)

**In Motion Dentists** complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.