



### How would you like us to communicate with you?

Our dental office sends appointment reminders, information about treatment, payment and insurance, and other communications. Please tell us how you would like us to communicate with you.

Your Name: \_\_\_\_\_

Please confirm your **MAILING** address:

\_\_\_\_\_

### For Phone, Email and Text Communications:

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Email address: \_\_\_\_\_

By checking the box (es), I consent to the following: The dental practice or its service provider may contact me to provide health care information such as appointment reminders and information about treatment, payment, my account, or insurance, using the following:

- Home phone
- Cell phone
- Email address
- All of the above

Please list any family members **that you would like to assign with YOUR phone numbers (ie: minor children):**

1. \_\_\_\_\_ 3. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_

*By signing below you are stating that the above is true and accurate.*

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

For Office Use Only:

- Eaglesoft Consent: Date: \_\_\_\_\_ / Initials: \_\_\_\_\_
- Weave Consent: Date: \_\_\_\_\_ / Initials: \_\_\_\_\_

**Los Osos Valley Dentistry**

**Michael Kobliska, DDS**

2098 9<sup>th</sup> Street, Suite C

Los Osos, CA 93402

**Acknowledgement of Receipt of Notice of Privacy Practices**

I, \_\_\_\_\_

(Please print name)

have received a copy of the Los Osos Valley Dentistry Notice of Privacy Practices.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Please print name

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

You may decline to sign this form by checking the box below.

I Decline to sign this form

\_\_\_\_\_  
Please print name

\*\*\*\*\*

**For Office Use Only**

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

- Individual declined to sign
  - Communication barriers prohibited obtaining the acknowledgement.
  - An emergency situation prevented us from obtaining acknowledgement
  - Other (please specify)
- \_\_\_\_\_

# Los Osos Valley Dentistry

## Michael Kobliska, DDS

2098 9<sup>th</sup> Street, Suite C

Los Osos, CA 93402

### Patient Acknowledgement of Receipt of Dental Materials Fact Sheet

I, \_\_\_\_\_  
(Please print name)

Acknowledge I have received a copy of the Dental Materials Fact Sheet form Michael Kobliska D.D.S., dated October 2001.

Signature

Date

\*\*If this acknowledgment is signed by a personal representative on behalf of the patient, please complete the following:

\_\_\_\_\_  
Please print name

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\*\*You may decline to sign this form by checking the box below.

I Decline to sign this form

\_\_\_\_\_  
Please print name

The Dental Board of California  
Dental Material Fact Sheet  
Adopted by the Board on October 17, 2001

As required by Chapter 801, Statutes of 1992, the Dental Board of California had prepared this fact sheet to summarize information on the most frequently used restorative dental materials. Information on this fact sheet is intended to encourage discussion between the patient and dentist regarding the selection of dental materials best suited for the patient's dental needs. It is not intended to be a complete guide to dental materials science.

The most frequently used materials in restorative dentistry are amalgam, composite resin, glass ionomer cement, resin-ionomer cement, porcelain (ceramic), porcelain (fused to metal), gold alloys (noble) and nickel or cobalt-chrome (base metal alloys). Each material has its own advantages and disadvantages, benefits and risks. These and other relevant factors are compared in the attached matrix titled "Comparisons of Restorative Dental Material." A Glossary of Terms" is also attached to assist the reader in understanding the terms used.

The statements made are supported by relevant, credible dental research published mainly between 1993 – 2001. In some cases, where contemporary research is sparse, we have indicated our best perceptions based upon information that predates 1993.

The reader should be aware that the outcome of dental treatment or durability of a restoration is not solely a function of material from which the restoration was made. The durability of any restoration is influenced by the dentist's technique when placing the restoration, the ancillary materials used in the procedure, and the patient's cooperation, during the procedure. Following restoration of the teeth, the longevity of the restoration will be strongly influenced by the patient's compliance with dental hygiene and home care, their diet and chewing habits.

\*\*\*\*\*

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- Communication barriers prohibited obtaining the acknowledgement.
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)

\_\_\_\_\_

insurance carrier. We do expect patients to be more interactive and responsible for communicating with your insurance carrier on any open claims.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. **It is the patient's responsibility to know if our office is contracting or non-contracting with their insurance plan.** Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect co-payments, co-insurance and deductibles, as outlined by your insurance carrier.

### Missed Appointments

We require notice of cancellations 24 hours in advance. This allows us to offer the appointment to another patient. We do however understand emergencies may arise where you are unable to provide a 24 hour notice. If you fail to keep your appointments without notifying us in advance, a missed appointment fee may apply. The fees are typically \$35.00 but not to exceed one-half of the cost of your scheduled appointment. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

I (Please print name) \_\_\_\_\_ I have read and understand the above financial policy.

Signature

Date

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

\_\_\_\_\_  
Please print name

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

You may decline to sign this form by checking the box below. In doing so, you agree to obtain a different dental provider.

I Decline to sign this form

**Los Osos Valley Dentistry**  
**Michael Kobliska, DDS**

2098 9<sup>th</sup> Street, Suite C  
Los Osos, CA 93402

**Acknowledgement of Receipt of Notice of Financial Agreement**

We, at Los Osos Valley Dentistry thank you for choosing us as your dental provider. We consider it a privilege to serve your needs and look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family. We believe your understanding of your financial responsibility is vital to that provider-patient relationship. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities please feel free to contact us at 805-528-2200.

We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients.

Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance by our staff.

We make payment as convenient as possible by accepting cash, money order, credit cards, check and care credit.

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within Los Osos Valley Dentistry.

**Interest**

Interest will incur if a balance remains unpaid after 60 days. If your balance is unpaid and no payment arrangement has been made after 120 days, your account may be sent to collections.

**Insurance**

**Please remember that your insurance policy is a contract between you and your insurance carrier.** We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their