TRANQUILITY
HEALTH

Email to: info@tranquilityhealth.com
Fax to: 925-644-2701
Mail to: 140 Mayhew Way, Suite 102, Pleasant Hill, CA 94523
Questions? Call us at: 925-644-2700

NEW PATIENT INFORMATION FORM

Tranquility Health manages onsite dental care to residents of senior living communities, including independent living facilities, assisted living communities, nursing homes, and continuing care retirement communities. Our affiliated doctors provide comprehensive care, including exams, digital x-rays, cleanings, fluoride treatment, oral cancer screenings, fillings, crowns/bridges, partials/dentures, extractions, and much more!

THE FIRST VISIT AND WHAT TO EXPECT

A new patient typically receives an initial comprehensive examination with oral cancer screening, x-rays, and cleaning with fluoride treatment. The patient must receive an exam to become a patient of record and to be seen for a cleaning. The doctor will complete a thorough review of the patient's current oral status and outline any needed treatment at the first appointment. Any treatment recommendations will be communicated to the patient or healthcare guardian for approval. After a treatment plan is signed, our Patient Care Coordinator will schedule the treatment visit with the Senior Living Community.

PRICING

Pricing at Tranquility Health is competitive with traditional practices and more convenient for the patient. Fees for House/Extended Care Facility Call (D9410) are always waived for regularly scheduled visits.

- New Patient Appointment $389
- Recare Appointment $356

LEVEL OF CARE SELECTION AND FREQUENCY

Recare Appointments	Recare appointments include a periodoic exam and prophylaxis cleaning. A prophylaxis cleaning includes scaling and polishing to remove coronal plaque, calculus, and stains. We also clean dentures with a professional ultrasonic cleaner during recare appointments. We default to every 3 months if this field is left blank. ➔ ☐ **Every 3 months (Recommended)** ☐ **Every 6 months** ☐ **No Recare**
Hygiene Therapy Program	The Hygiene Therapy Program is a weekly toothbrushing, flossing, denture check, and hygiene instruction program. This supplemental program is in addition to recare appointments. ➔ ☐ **Yes, If Available ($41 per week)** ☐ **No** ☐ **Maybe- I'd like to learn more**

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PATIENT INFORMATION

First Name _____ Last Name _____ Date of Birth _____

The person filling out this form is the: ☐ Patient ☐ POA or Responsible Party

Gender: ☐ Male ☐ Female

Patient Telephone _____ Patient Email _____

Community/Facility Name (clarify property if multi-location brand) _____

Community/Facility City _____ Room # _____

Patient lives in:

☐ Assisted Living/Personal Care ☐ Skilled Nursing/Long-Term Care
☐ Independent Living ☐ Memory Care

Patient prefers:

☐ Mornings ☐ Afternoons ☐ Either

Music Preference:

☐ Big Band ☐ Hymns ☐ Swing ☐ Oldies
☐ Jazz ☐ Classical ☐ Other: _____

PRIMARY RESPONSIBLE PARTY/POWER OF ATTORNEY (IF APPLICABLE)

First Name _____ Last Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Telephone (Home) _____ Telephone (Cell) _____

Email _____ Relation to the Patient _____

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MEDICAL HISTORY FORM

Check if the patient has or has ever had:

- ☐ Allergies, hay fever, sinusitis
- ☐ Alzheimer's/Dementia
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial heart valves
- ☐ Artificial joints; Surgery Date:_____
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bleeding abnormally with operations or surgery
- ☐ Blood disease, clotting disorders
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ COPD
- ☐ Cortisone treatments
- ☐ Cough, persistent or bloody
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting or fall risk
- ☐ Glaucoma
- ☐ Gout
- ☐ Headaches
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Heart problems
- ☐ Heart valve replacement
- ☐ Hepatitis
- ☐ Herpes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Any immune deficiency
- ☐ Jaundice
- ☐ Kidney disease
- ☐ Low blood pressure
- ☐ Mitral valve prolapse
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Pacemaker
- ☐ Radiation treatments (specify if head/neck)
- ☐ Respiratory disease
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Shortness of breath
- ☐ Sinus trouble
- ☐ Sickle cell anemia
- ☐ Slow healing wounds
- ☐ Stroke
- ☐ Swelling of feet or ankles
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or growth on head/neck
- ☐ Ulcer
- ☐ Venereal disease
- ☐ Weight loss, unexplained
- ☐ Allergic to Aspirin
- ☐ Allergic to Penicillin
- ☐ Allergic to Latex
- ☐ Allergic to Sulfa Drugs
- ☐ Allergic reaction to Novocaine, local, or general anesthetics

If "Yes" to any of the above, please describe:

_____

_____

Has the patient gone to the hospital/emergency room in the last three years? ☐ Yes ☐ No

If YES, explain:_____

Is the patient currently taking prescription blood thinners? ☐ Yes ☐ No

If yes, please specify:_____

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Has the patient ever taken medications/injections for osteoporosis (bisphosphonates)? ☐ Yes ☐ No

List any medications that the patient is taking:

_____

_____

_____

_____

List any known allergies the patient has:

_____

_____

Primary Care Physician/MD: _____ Contact Information: _____

DENTAL HISTORY

Date of last dental exam? _____

Has the patient ever been prescribed pre-medication for a dental visit? ☐ Yes ☐ No

Does the patient wear dentures (complete or partials)? ☐ Yes ☐ No

Current dental pain/concerns:

_____

_____

I hereby certify that I have read the foregoing and filled out this questionnaire completely. I have advised you of all medical problems of which I am aware. I further certify that I consent to the performing of an examination.

Print Name of Patient/POA/Guardian: _____

Signature of Patient/POA/Guardian: _____ Date: _____

Signature of Reviewing Doctor: _____ Date:_____

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FINANCIAL POLICY / CREDIT CARD AUTHORIZATION FORM

DENTAL INSURANCE

We are an out-of-network provider (not in-network) for all insurance plans. We assist our clients in filing claims by providing them with ledgers (receipts) that indicate the services provided and allows them to submit claims. Clients are then reimbursed directly by the insurance companies.

FINANICAL DISCLOSURES

You understand payment is due **in full at the time of services** and is not dependent on the reimbursement you may receive from your dental insurance plan. The fee for a New Patient Appointment is $389. The fee for a Recare Appointment is $356. A 10% late fee will be applied to any outstanding balance not paid within 30 days of services being rendered.

BILLING INFORMATION

All information will remain confidential.

Cardholder name (as shown on the card): _____

Billing Address: _____

City, State & ZIP: _____

Credit Card Information

Card Type: ☐ VISA ☐ MasterCard ☐ Discover

Card Number: _____

Expiration Date: _____ Security Code/CVC2/CVV2: _____

Amount to charge: $ _____

AUTHORIZATION

☐ I have read and understand the above financial policy. I understand that by signing this form, I am responsible for payment and agree to all terms as stated above.

I authorize Tranquility Health to charge my credit card provided herein for agreed amount listed above. I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Signature Date