HITOMI DENTISTRY
p. 626.443.5900
f. 626.443.2674
11525 lambert ave
el monte, ca 91732
office@hitomidentistry.com
www.hitomidentistry.com

FINANCIAL POLICY

Thank you for choosing Hitomi Dentistry! 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, MasterCard, American Express, JCB, and Discover Card.
- NO INTEREST[1] Payment Plans[2] from CareCredit and Chase.

Please note:

- For the patients **without** dental insurance Hitomi Dentistry requires 100% payment on the day of treatment. For treatment plans requiring more than 2 appointments, alternative payment arrangements may be provided, however, in most cases - 50% will be paid on 1st visit, other 50% on the second.

- For patients **with** dental insurance Hitomi Dentistry is happy to work with your carrier and directly bill them for reimbursement for your treatment. **Your co-payment is required on the day of treatment.** If for some reason we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees.

-Your balance payment is required within 10 days after monthly statement was received. All overdue accounts will be sent to collection agency and collection fees will be added to overdue balance.

- Appointment cancelation is required not later than 48 hours prior, otherwise $40.00 cancelation fee will be applied to your account.

We are here to help you get the dentistry you need. Should you have any questions please do not hesitate to ask.

Patient, Parent or Guardian Signature Date

Patient Name (Please Print)

[1]If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.
[2]Subject to credit approval.

***PLEASE FILL OUT BOTH SIDES OF FORMS (Double Sided) THANK YOU!**

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INFORMED CONSENT FOR RADIOGRAPHS (X-RAYS)

This Office follows the guidelines of the American Dental Association and recommends that FULL MOUTH XRAYS (FMX) BE TAKEN ONCE EVERY 3 TO 5 YEARS and BITE-WING X-RAYS every year for caries active patients and 1-2 years for routine cases.

*X-RAYS are used to diagnose:

1) Extent of **bone loss** associated with PERIODONTAL DISEASE
2) Interproximal caries – **Decay in between the teeth**
3) **Pathology** of pulp
4) Integrity of root canal fillings
5) Verify tooth or root structure
6) Supernumerary teeth, impacted teeth
7) Pathologic root resorption
8) Third molar location and position
9) Bone pathology
10) Need for interceptive orthopedic/orthodontic treatment
11) What is normal for you. This will become important if you ever have trauma to your face and teeth due to an auto/bike accident or sports injury for example.

*__Current X-rays will be necessary__ before any diagnosis can be finalized. NO TEETH WILL BE EXTRACTED without a current PA (Periapical x-ray showing the root and surrounding bone and soft tissue) or panorex film. No fillings will be placed without current bite-wings and/or PAs of the tooth. **NO EXCEPTIONS**.

*Children and Adults: If any decay or dental infection (Abscess) is obvious on visual inspection, x-ray will be necessary to assess the extent of damage to the tooth structure. If your child is uncooperative, you will be referred to a pediatric dentist for treatment. Bite-wings and occlusal films are recommended for school age children 5 years and up. Occlusal films and bite-wing x-rays may be suggested at age 3.5 years to 4 years if there is no spacing between the teeth and if we suspect caries.

*Pregnant woman: X-RAYS WILL BE AVOIDED UNLESS IT IS AN EMERGENCY. Please inform this office if you think you are pregnant and X-rays will be postponed.

I have READ, UNDERSTOOD, AND CONSENT TO HAVING X-RAYS TAKEN IN THIS OFFICE.

_____ _____
PATIENT OR GUARDIAN SIGNATURE DATE

_____ _____
STAFF SIGNATURE DATE

I REFUSE TO HAVE X-RAYS TAKEN AT THIS TIME. I UNDERSTAND THAT A COMPLETE AND THOROUGH DIAGNOSIS IS NOT POSSIBLE. I WILL NOT HOLD THE DENTIST OR STAFF RESPONSIBLE FOR NOT INFORMING ME OF ANY OF THE CONDITIONS LISTED ABOVE. I FURTHER UNDERSTAND THAT IF I HAVE BEEN A REGULAR PATIENT OF THIS PRACTICE FOR TWO YEARS, I MUST HAVE A FULL MOUTH X-RAYS ON FILE (THESE CAN BE FROM A PREVIOUS DENTIST AS LONG AS THEY ARE NOT OVER 3 YEARS OLD). We reserve the right to terminate treatment for incomplete records.

_____ _____
PATIENT OR GUARDIAN SIGNATURE DATE

_____ _____
STAFF SIGNATURE DATE

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Patient Information Sheet

Thank you for choosing Hitomi Dentistry /Dr Trent Kanemaki DDS!
Please tell us about yourself. All our records are now computerized, once this information sheet is scanned to our database, it will be destroyed.

Patient's First Name:
Patient's MI:
Patient's Last Name:
Patient's DOB:
Patient's SSN:
Patient's Address:
Home Phone:
Cell Phone:
Work Phone:
Email:
I agree to receive emails from my dentist: YES / NO
Employer:
Primary Insurance:
Subscriber Information (Disregard if same as above):
Subscriber 1st and last names:
Subscriber DOB:
Subscriber SSN:
Patient's relationship to Subscriber:
Secondary Insurance:
Subscriber Information (Disregard if same as above):
Subscriber 1st and last names:
Subscriber DOB:
Subscriber SSN:
Patient's relationship to Subscriber:
Emergency Contact name:
Emergency Contact Tel number:
Who should we thank for referring you to our office? Yelp/Facebook/Other (Circle)
If Other:

Date: Signature:

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Medical Insurance Information:

PATIENT'S FIRST AND LAST NAME:
Primary MEDICAL Insurance name:
PLAN (PPO, HMO, POS etc.):
Subscriber 1st and last names:
Subscriber ID:
Subscriber DOB:
Subscriber SSN:
Patient's relationship to Subscriber:
Secondary MEDICAL Insurance name:
PLAN (PPO, HMO, POS etc.):
Subscriber 1st and last names:
Subscriber ID:
Subscriber DOB:
Subscriber SSN:
Patient's relationship to Subscriber:

I hereby authorize the release of all medical information necessary to process my claims and I authorize release of this same information, when necessary, to other providers rendering medical/dental care, as well as to labs that need my information to make diagnosis or fabricate an appliance necessary for my treatment. I assign all medical and surgical benefits, including major medical benefits to which I am entitled, to Hitomi Dentistry. This assignment will remain in effect until revoked by me in writing.

Date: Signature:

***PLEASE FILL OUT BOTH SIDES OF FORMS (Double Sided) THANK YOU!**