DUBLIN PLAZA DENTAL

General & Cosmetic Dentistry For All Ages

Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #: _____ Birth Date:_____ Driver's Lic #_____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call:_____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: _____ E-mail_____
Street

_____
City State Zip Code

Person to contact in case of emergency: Name:_____Relation:_____Phone:_____

Health Information

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ **Allergies** _____
- ☐ **Latex Allergy**
- ☐ Anemia
- ☐ Arthritis
- ☐ **Artificial Joints/Implants**
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ **Heart Murmur**
- ☐ Hepatitis
- ☐ **High Blood Pressure**
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnant Now**
- ☐ **Nursing Baby**
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ **Smoking/Tobacco Use**
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ **Penicillin Allergy**

OTHER:

- ☐ _____
- ☐ _____
- ☐ _____

List Your Medications

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of Physician: _____ Phone:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

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

_____ Date: _____
Signature of patient, parent or guardian

DOCTOR'S SIGNATURE: _____ DATE: _____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another Patient ☐ Other _____

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ Post Card ☐ Work ☐ Insurance ☐ Walk-In

Name of person or office referring you to our practice:_____

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Patient Name _____Signature_____Date_____

DENTAL HISTORY

Reason for this visit ? _____

When was your last visit with a dentist ? _____ What was done then ? _____

How often did you usually visit a dentist ? _____

Previous dentist (name and location):_____

_____

Have you had a full series of dental x-rays taken before ? _____ When & where ? _____

How often do you brush your teeth ? _____

How often do you floss your teeth ? _____

Is your drinking water fluoridated ? _____ (Discuss with the doctor if not sure.)

	YES	NO
Do your gums bleed while brushing or flossing ?	☐	☐
Are your teeth sensitive to hot or cold ?	☐	☐
Are your teeth sensitive to sweet or sour ?	☐	☐
Do you feel pain with any teeth or in mouth ?	☐	☐
Do you have any sores or lumps in or near mouth ?	☐	☐
Have you had any head, neck, or jaw injuries ?	☐	☐
Explain: _____		
Have you experienced any of the following in your jaw ?		
Clicking ?	☐	☐
Pain (joint, ear, side of face) ?	☐	☐
Difficulty in opening or closing ?	☐	☐
Difficulty in chewing ?	☐	☐
Do you have frequent headaches ?	☐	☐
Do you clench or grind your teeth ?	☐	☐
During day or night ? _____		

	YES	NO
Do you bite your lips or cheeks frequently ?	☐	☐
Have you noticed any loosening of your teeth ?	☐	☐
Does food get caught between your teeth ?	☐	☐
Have you ever had "deep cleaning" or "gum" treatment ? When ? _____	☐	☐
Ever worn a bite plate or other appliance ?	☐	☐
Have you ever had any difficult tooth extractions ?	☐	☐
Ever had prolonged bleeding after extractions ?	☐	☐
Do you wear dentures or partials ? How old are current ones ? _____	☐	☐
Have you ever received oral hygiene instructions regarding the care of your teeth and gums ?	☐	☐

If you could change *ANYTHING* about your smile, what would you change ?

_____

Doctor's Comments: _____

_____Signature_____Date _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____ Driver's Lic #_____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____

Address: _____

Street Apartment #

_____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

Authorization, Release, & Agreement to Pay for Services Rendered

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

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me to third party payors and / or other health practitioners pertaining to your overall care.

I authorize & hereby request my insurance company to pay directly to the dentist (or dental office) any insurance benefits otherwise payable to me arising from service received at this office.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. I understand understand that my dental insurance carrier may pay less than the actual bill for services, thus I am responsible for any unpaid balance.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

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

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his 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 as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

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

I have read the above conditions of treatment & payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent, or guardian

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INFORMED CONSENT FORM

Patients Full Name_____

I. Diagnostic Services
I understand that proper evaluation my dental condition and needs requires a combination of visual exam, x-rays, and tests. I agree to receiving any required diagnostic services to being performed where appropriate to help determine my dental needs.

Initial_____.

II. Drugs and Medications
I understand that antibiotics, analgesics, and other medications can cause allergic reactions, eg. redness and swelling of the tissues, pain, itching, vomiting, and/or anaphylactic shock. It is my responsibility to let doctor know of any allergies or history of adverse reactions to any medications.

Initial_____.

III. Changes in Treatment Plan
I understand that during treatment it may be necessary to change or add procedures because of conditions that where not evident during the initial examination but where found after starting treatment. I give my permission to the Dentist to make any and all changes/additions as he sees necessary. Changes will be discussed with you.

Initial_____.

IV. Removal of Teeth
Alternatives to removal have been explained to me and I authorize the Dentist to remove treatment planned teeth and any others necessary for reasons in paragraph III. I understand removing teeth does not always remove all of the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed and I understand that I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.

Initial_____.

V. Crowns, Bridges, and Veneers
I understand that sometimes it may mot be possible to match the color of artificial teeth exactly to natural teeth. I further understand that I may be wearing temporary restorations, which may come off easily and that I must be careful to ensure that they are kept on until the permanent restorations are delivered. I realize the final opportunity for me to make changes to my new crown, bridge, or veneer (including shape, fit, size, and color) will be before cementation. It is also my responsibility to return for permanent cementation about two weeks from tooth impression as scheduled. Excessive delays may allow for tooth movement. This may necessitate a remake of the restoration altogether. I understand there will be additional charges for remakes due to my delaying permanent cementation or failure to comply with care instruction for the temporaries.

Initial_____.

VI. Endodontic Treatment
I realize there is no guarantee that a root canal treatment will save my tooth; and that complications can occur from the treatment, and root canal filling material may extend through the tooth, which does not necessarily affect the success of treatment. I understand that endodontic files and instruments are very fine tools… stresses vented in their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures and/or referral to a specialist may be necessary following root canal treatment, the cost of which is my responsibility. I understand the tooth may be lost despite all reasonable efforts to save it.

Initial_____.

VII. Periodontal Loss
I understand that gum disease is a serious condition causing gum and bone inflammation or loss; and it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including surgery, gum replacements, specialist consultation, and/or extractions. I understand that undertaking any dental procedures may have a future adverse affect on my periodontal condition. I understand that following the Dentist recommended treatment regimens & home care instructions will play a very important role in the success of my treatment and overall dental health in general.

Initial_____.

VIII. Fillings
I understand that care must be exercised in chewing on (silver amalgam) fillings especially during the first twenty-four hours to avoid breakage. I understand that temporary, significant sensitivity is a common after effect of a newly placed restoration. However, I understand that deeper/larger restorations can sometimes lead to irreversible nerve inflammation (sensitivity), which may require additional treatment (such as root canal).

Initial_____.

IX. Dentures
I understand the wearing of dentures is difficult. Sore spots, altered speech / taste, and difficulty in eating are common problems. Immediate dentures (placement of denture immediately after extractions) may be painful. Immediate dentures may need several adjustments and relines. A permanent reline will be needed later; this is not included in the denture fee. I understand it is my responsibility to return for delivery of the dentures as scheduled. I understand that failure to keep my appointment may result in poorly fitting dentures. If a remake is required due to my delays of more than thirty days, there will be additional charges.

Initial_____.

I understand that dentistry is not an exact science and therefore, reputable practitioners cannot realistically guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding my dental treatment, which I have requested and authorized. I understand that no other dentist is responsible for my dental treatment. I hereby authorize the treating dentist (or dental auxiliary where appropriate) to proceed with and perform the dental restorations and treatments as explained to me. I understand that quoted treatment fees and insurance/patient portions are only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the coarse of treatment. I understand that regardless of any dental insurance coverage that I may have, I am responsible for payment of dental fees for services rendered. I agree to pay any attorneys fees, collection fees, or court costs that may be incurred to satisfy this obligation.

Patient/Guardian Signature_____Date_____ Doctor Signature_____Date_____

DUBLIN PLAZA DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received or reviewed a copy of this office's Notice of Privacy Practices which is posted near the front desk.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

DENTAL MATERIALS FACT SHEET RECEIPT ACKNOWLEDGEMENT

I, _____, acknowledge that I have received or reviewed a copy of the Dental Board of California, Dental Materials Fact Sheet from this office.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).