We Would Like to Get to Know You Better!

Date_____

Full Name_____ Phone (Hm) (____)_____-_____ (Wk) (____)_____-_____

Address_____ City_____ State _____ Zip_____

Email_____ Date of birth_____ Social Security #_____-_____-_____

Drivers License #_____ Marital status_____ Spouse's name_____

Occupation_____ Employer_____ Work Hours_____

Contact in case of emergency _____ Phone (____)_____-_____

When was your last dental appointment? _____ Person responsible for your dental investment_____

How did you hear about us? _____ Why did you leave your last dentist? _____

We Want to Take Care of Your Concerns and Needs First…

What are your present dental problems? _____

Do you avoid brushing any part of your mouth? ( ) Yes ( ) No

Do your gums bleed when brushing? ( ) Yes ( ) No

Are your teeth sensitive to sweets, hot/cold, or biting pressure? ( ) Yes ( ) No

I want to know about longer lasting solutions that may cost more. ( ) Yes ( ) No

Are you dissatisfied with your teeth and their appearance? ( ) Yes ( ) No

Does dental treatment make you nervous?
( ) No ( ) Slightly ( ) Moderately ( ) Very

I think my dental health is…
( ) Excellent ( ) Good ( ) Fair ( ) Poor

If I could change my smile I would make my teeth…
( ) Whiter ( ) Straighter ( ) Close Spaces ( ) Repair Chips

Other concerns/needs of mine are _____

For Insurance Purposes…

Name of policy holder_____ Policy holder Social Security # _____ - _____ - _____

Policy holder's date of birth_____ Employer_____ Name of ins. co._____

Insurance company's Phone_____ Group #_____ Ins. Co. Address_____

Are you covered by another plan? If so please complete the following…

Name of policy holder_____ Policy holder Social Security # _____ - _____ - _____

Policy holder's date of birth_____ Employer_____ Name of ins. co._____

Insurance company's Phone_____ Group #_____ Ins. Co. Address_____

CONFIDENTIAL HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?
   If NO, explain: _____
2. Yes / No Has there been a change in your health within the last year?
   If YES, explain: _____
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain: _____
4. Yes / No Are you being treated by a physician now? If YES, explain: _____
   Date of last medical exam? _____ Reason for exam: _____
5. Yes / No Have you had problems with prior dental treatment?
   If YES, explain: _____
   Date of last dental exam: _____ Name of last treating dentist: _____
6. Yes / No Are you in pain now?
   If YES, explain: _____

II. HAVE EVER YOU EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Chest pain (angina)	Yes / No	Blood in stools	Yes / No	Frequent vomiting
Yes / No	Fainting spells	Yes / No	Diarrhea or constipation	Yes / No	Jaundice
Yes / No	Recent significant weight loss	Yes / No	Frequent urination	Yes / No	Dry mouth
Yes / No	Fever	Yes / No	Difficulty urinating	Yes / No	Excessive thirst
Yes / No	Night sweats	Yes / No	Ringing in ears	Yes / No	Difficulty swallowing
Yes / No	Persistent cough	Yes / No	Headaches	Yes / No	Swollen ankles
Yes / No	Coughing up blood	Yes / No	Dizziness	Yes / No	Joint pain or stiffness
Yes / No	Bleeding problems	Yes / No	Blurred vision	Yes / No	Shortness of breath
Yes / No	Blood in urine	Yes / No	Bruise easily	Yes / No	Sinus problems

Other: _____

III. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Heart disease	Yes / No	AIDS/HIV	Yes / No	Psychiatric care
Yes / No	Family history of heart disease	Yes / No	Surgeries	Yes / No	Osteoporosis
Yes / No	Heart attack	Yes / No	Hospitalization	Yes / No	Thyroid disease
Yes / No	Artificial joint	Yes / No	Diabetes	Yes / No	Asthma
Yes / No	Stomach problems or ulcers	Yes / No	Family history of diabetes	Yes / No	Hepatitis
Yes / No	Heart defects	Yes / No	Tumors or cancer	Yes / No	Sexual transmitted disease
Yes / No	Heart murmurs	Yes / No	Chemotherapy	Yes / No	Herpes
Yes / No	Rheumatic fever	Yes / No	Radiation	Yes / No	Canker or cold sores
Yes / No	Skin disease	Yes / No	Arthritis, rheumatism	Yes / No	Anemia
Yes / No	Hardening of arteries	Yes / No	Emphysema or other lung disease	Yes / No	Liver disease
Yes / No	High blood pressure	Yes / No	Kidney or bladder disease	Yes / No	Eye disease
Yes / No	Seizures	Yes / No	Stroke	Yes / No	Transplants
Yes / No	Cosmetic surgery	Yes / No	Eating disorders	Yes / No	Tuberculosis

Other: _____

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Aspirin	Yes / No	Valium or other sedatives	Yes / No	Codeine or other narcotics
Yes / No	Penicillin or other antibiotics	Yes / No	Latex	Yes / No	Food
Yes / No	Nitrous oxide	Yes / No	Local anesthetic	Yes / No	Metal

Others: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?
(Please circle Yes or No for each)

Yes / No	Recreational drugs	Yes / No	Tobacco in any form	Yes / No	Antibiotics
Yes / No	Over-the-counter medicines	Yes / No	Alcohol	Yes / No	Supplements
Yes / No	Weight loss medications	Yes / No	Bisphosphonate (Fosamax)	Yes / No	Aspirin
Yes / No	Anti-Depressants	Yes / No	Herbal supplements		

Please list all prescription medications: _____

VI. WOMEN ONLY (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, what month? _____

Yes / No Are you nursing?

Yes / No Are you taking birth control pills?

VII. ALL PATIENTS (Please circle Yes or No for each)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____

_____

Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: _____

Yes / No Have you ever taken Fen-Phen? If YES, when: _____

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

Whom would you like us to contact in case of an emergency?

Name:_____ **Relationship:**_____ **Phone Number:**_____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____	_____	_____	_____
Signature of Patient (Parent or Guardian)	**Date**	**Signature of Dentist**	**Date**

MEDICAL UPDATES
I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Informed Consent

Patient's Name_____

I understand that by signing below and initialing any of the following items that I request and authorize the procedure to be done and have read and understand the possible risks and complications of the procedure(s).

Initials_____

1) X-Rays & Examination

I understand that I will be receiving a dental examination from a state licensed dental practitioner. I understand that while X-rays are taken on my teeth that I will be exposed to a minimal amount of radiation as part of the necessary requirements to complete a thorough and comprehensive examination. I also understand that if I am pregnant radiation exposure posses a serious threat to the life and health of my unborn child. **Pregnant women are required to have medical release from their Medical Doctor prior to X-rays and Dental treatment.**

Initials_____

2) Changes in Treatment Plan

I understand that during treatment it may be necessary to change procedures or add procedures because of conditions discovered while working on the teeth that were not found during examination. I understand that there may be unforeseen changes that may occur during treatment. I understand that whenever possible, I will be informed of any treatment changes in advance. I give my permission to the Dentist to make any and/or all changes and additions as necessary.

Initials_____

3) Drugs and Medication

I understand that antibiotics, analgesics and other medications can cause allergic reactions. The reactions can cause redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock.

Initials_____

4) Removal of Teeth

Alternatives for tooth removal have been explained to me (root canal therapy, crowns, and periodontal surgery) and I authorize the Dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #2. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the following risks involved in having teeth removed; these are pain, spread of infection, dry socket, swelling, fractured jaw, loss of feeling in my teeth, lips, tongue, and surrounding tissue that can last for an indefinite period of time. I understand I may need further treatment by a specialist, the cost of which is my responsibility. Initials_____

5) Crowns and Bridges.

I understand that I may be wearing temporary crowns, and that I must be careful to ensure that they are not removed until the permanent crowns are delivered. I understand that sometimes it is not possible to match the color of my natural teeth with artificial teeth. I realize the last opportunity to make changes in my crown, cap, or bridge will be before permanent cementation. I must return to the dentist for permanent cementation within 20 days from tooth preparation. Extended delays between the time of tooth preparation and crown cementation may allow for tooth movement, accumulation of bacteria, and/or infection of tooth structure and the surrounding tissues. This may cause the necessity to remake the crown, cap, or bridge, and even could lead to tooth loss. I understand there will be additional charges for remakes due to my delaying permanent cementation.

Initials_____

6) Root Canals/Endodontic Treatment

I understand that there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that sometimes root canal filling material may extend through the tooth which does not necessarily effect the success of the treatment. I understand that endodontic files and reamers can separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment.

Initials_____

7) Periodontal Loss

I understand that I have a condition that causes gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have future adverse effect on my periodontal condition.

Initials_____

8) Fillings

I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling. If the sensitivity continues, I understand that a root canal may be needed, even though the tooth may not have hurt prior to the filling being done.

Initials_____

9) Dentures

I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate denture (placement of denture immediately after extractions) may be painful. Immediate denture may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. (Initials_____) I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of more than 30 days, there will be additional charges.

Initials_____

I understand that there has been no guarantee or assurance made by anyone in regards to my dental treatment that I have authorized. I also acknowledge that I am responsible for payment of all my dental fees regardless of any dental insurance coverage.
If you are unable to keep an appointment, please notify us at least 24 hours in advance. Failure to do so will result in a broken appointment fee of $55 per hour that was reserved for you.

Signature of Patient_____Date_____

Signature of Doctor_____Date_____

Patient Acknowledgment of
Receipt of Notice of Privacy Practices

As of January 1, 2002, the Dental Board of California now requires that we distribute to our patients a copy the Health Insurance Portability and Accountability Act (HIPAA) requires effective April 14, 2003 that patients be given a copy of our Notice of Privacy Practice.

If you would, please print and sign your name below.

I, _____, acknowledge I have received from this office

1. A copy of the Notice of Privacy Practices.

_____ _____
Patient Signature or Personal Representative Date

If signed by a Personal Representative of the Patient, describe the representative's authority to act for the patient. _____
_____
_____

For Office Use

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 acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____
_____
_____
_____

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 applicable 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 concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/14/2003), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

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

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make

reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 for each page, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

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 an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.

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 to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact : Any Staff Member