



PATIENT REGISTRATION

Email:		Preferred Name:		Date:	
Name:		Home Phone:		Cell Phone:	
Last:	First	MI:	()	()	()
Address:		City:	State:	Zip:	
SSN:	Date of Birth:	Sex: M F	Occupation:		
Emergency Contact:		Relationship:		Home Phone:	
Name:				()	
If you are completing this form for another person, what is your relationship to that person?					
Name:			Relationship:		

DENTAL INFORMATION

For the following questions, please circle (Y) for yes or (N) for no to the following questions.

Do your gums bleed when you brush or floss?	Y N	Do you have earaches or neck pains?	Y N
Are your teeth sensitive to cold, hot, sweets or pressure?	Y N	Do you have any clicking, popping or discomfort in the jaw?	Y N
Does food or floss catch between your teeth?	Y N	Do you brux or grind your teeth?	Y N
Is your mouth dry?	Y N	Do you have sores or ulcers in your mouth?	Y N
Have you had any periodontal (gum) treatments?	Y N	Do you wear dentures or partials?	Y N
Have you ever had orthodontic (braces) treatment?	Y N	Do you participate in active recreational activities?	Y N
Have you had any problems associated with previous dental treatment?	Y N	Have you ever had a serious injury to your head or mouth?	Y N
Is your home water supply fluoridated?	Y N	Date of your last exam?	X-rays?
Do you drink bottled or filtered water?	Y N	What was done at the time?	
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY		What is the reason for your visit today?	
Are you currently experiencing dental pain or discomfort?	Y N		

MEDICAL INFORMATION

Please circle (Y) for yes or (N) for no to indicate if you have or have not had any of the following.

Physician Name:		Address:		Phone:	
				()	
Are you now under the care of a physician?	Y N	Are you in good health?	Y N		
If yes, what condition is being treated?		Have you had a serious illness, operation or been hospitalized in the past 5 years?	Y N		
Date of your last physical:		Illness/problem:			
Are you taking or have you recently taken any prescription or over the counter medicine(s)?				Y N	
Do you use controlled substances (drugs)?				Y N	
If yes, please list all, including vitamin, natural or herbal preparations and/or diet supplements:	WOMEN ONLY				
	Are you pregnant?			Y N	
	Number of weeks _____				
	Taking birth control pills or hormonal replacement?			Y N	
	Nursing?			Y N	

MEDICAL INFORMATION Please circle (Y) for yes or (N) for no, to indicate if you have or have not had any of the following

Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?	Y	N
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease?	Y	N
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? If yes, date treatment began:	Y	N
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Date: _____ If yes, have you had any complications?	Y	N
Allergies- Are you allergic to or have you had a reaction to any of the following? If yes, specify reaction.		
Local anesthetics	Y	N
Aspirin	Y	N
Penicillin or other antibiotics	Y	N
Barbiturates, sedatives, or sleeping pills	Y	N
Sulfa drugs	Y	N
Codeine or other narcotics	Y	N
Other:		

Please circle (Y) or (N) to indicate if you have or have not had any of the following diseases or problems											
Heart murmur	Y	N	Anemia	Y	N	Chronic pain	Y	N	Sleep disorder	Y	N
Mitral valve prolapse	Y	N	Blood transfusion	Y	N	Diabetes	Y	N	Kidney problems	Y	N
Artificial heart valves	Y	N	Hemophilia	Y	N	Eating disorder	Y	N	Night sweats	Y	N
Rheumatic fever	Y	N	AIDS or HIV infection	Y	N	Malnutrition	Y	N	Osteoporosis	Y	N
Cardiovascular disease	Y	N	Arthritis	Y	N	Gastrointestinal Disease	Y	N	Mental health disorders	Y	N
Angina	Y	N	Autoimmune disease	Y	N	Ulcers	Y	N	Excessive urination	Y	N
Arteriosclerosis	Y	N	Rheumatoid arthritis	Y	N	G.E reflux/ persistent Heartburn	Y	N	Persistent swollen glands in neck	Y	N
Congestive heart failure	Y	N	Systemic lupus-erythematosus	Y	N	Thyroid problems	Y	N	Severe headaches/migraines	Y	N
Damaged heart valves	Y	N	Bronchitis	Y	N	Stroke	Y	N	Severe or rapid weight loss	Y	N
Heart attack	Y	N	Emphysema	Y	N	Glaucoma	Y	N	Sexually transmitted disease	Y	N
Low blood pressure	Y	N	Sinus trouble	Y	N	Epilepsy	Y	N	Coronary heart failure	Y	N
High blood pressure	Y	N	Tuberculosis	Y	N	Hepatitis, jaundice or liver disease	Y	N	Other:		
Congenital heart defect	Y	N	Cancer/chemotherapy Radiation	Y	N	Fainting spells/seizures	Y	N			
Pacemaker	Y	N	Chest pain upon exertion	Y	N	Neurological disorders	Y	N			
Rheumatic heart disease	Y	N	Asthma	Y	N						
Abnormal bleeding	Y	N									

I certify I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or staff responsible for any action they take or do not take because of errors or omissions that I may have made in the completion form.

Signature of patient/legal guardian: _____ **Signature of Dentist:** _____ **Date:** _____

RECALL REVIEW Mark any changes to your health history since your last dental visit and sign below

Signature of patient/legal guardian:	Signature of Dentist:	Date:
Signature of patient/legal guardian:	Signature of Dentist:	Date:
Signature of patient/legal guardian:	Signature of Dentist:	Date:



DENTAL INSURANCE

<u>PRIMARY INSURANCE</u>	<u>SECONDARY INSURANCE</u>
Name of primary insured: <i>Last</i> _____ <i>first</i> _____	Name of primary insured: <i>Last</i> _____ <i>first</i> _____
SSN of primary: _____ D.O.B: _____	SSN of primary: _____ D.O.B: _____
Relationship to primary: self spouse child other	Relationship to primary: self spouse child other
Insurance Company: _____ Address: _____ Enrollee ID: _____ Group: _____	Insurance Company: _____ Address: _____ Enrollee ID: _____ Group: _____
Employer: _____ Address: _____ If Student, Name of College: _____	Employer: _____ Address: _____ If Student, Name of College: _____

PHARMACY CONTACT

PHARMACY NAME: _____	PHONE: _____
ADDRESS: _____	

How did you hear about us?

- Internet search
 Mailer
 Website
 Referral- *name:* _____
 Other- *specify:* _____

OFFICE POLICIES

- 1) RETURNED CHECKS: There will be a \$25 fee for all the returned or stopped checks after services are rendered.
- 2) MISSED CANCELLED APPOINTMENTS: We know your time is valuable and we try to schedule in the best fit possible. Please be courteous and notify our office as soon as you know you will be unable to make a previously scheduled appointment. If it is necessary to cancel your appointment, we require a 24 HOUR NOTICE. Appointments cancelled in less than 24 hours or patients who do not show up for their scheduled appointment will incur a \$20 cancellation fee.
- 3) X-RAY/RECORD DUPLICATION: We are more than happy to send digital images to other dental specialist or provide you a copy. There will be a \$25 fee for x-ray/record duplication.

I the undersigned, certify that I have read, understand and agree to abide by the above office policies.

Patient Signature: _____ Date: _____



GENERAL DENTISTRY – INFORMED CONSENT

14150 Culver Drive, Suite 204
Irvine, CA 92604
Tel: 949 726 1001

All patients – Please complete items 1 through 4 below and 5 through 10 as needed

1] EXAMINATIONS AND X-RAYS

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. (Initials _____)

2] DRUGS, MEDICATIONS AND SEDATION

I have been informed and understanding that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 1-2 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives. (Initials _____)

3] CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary. (Initials _____)

4] TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)

I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility. (Initials _____)

5] FILLINGS

I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I understand that sensitivity is a common after effect of a newly placed filling. (Initials _____)

6] REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crowns, periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #3. 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 risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Parasthesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility. (Initials _____)

7] CROWNS, BRIDGES, CAPS, VENEERS AND BONDING

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize that the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation. It has been explained to me that, in a very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modifications of daily cleaning procedures. (Initials _____)

8] DENTURES – COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing those appliances have been explained to me, including looseness, soreness and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement and color) will be in the “teeth in wax” try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. (Initials _____)

9] ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). (Initials _____)

10] PERIODONTAL TREATMENT

I understand that I have a serious condition causing gum inflammation and/or bone loss, and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery, and/or extractions. I understand the success of any treatment depends in part on my efforts to brush and floss daily, receive cleaning as directed, follow a healthy diet, avoid tobacco products and follow other recommendations. (Initials _____)

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist other than the treating Dentist nor Irvine Smile Arts Dentistry is responsible for my dental treatment. I acknowledge the receipt of and understand postoperative instructions and have been given an appointment date to return.

Signature: _____

Date: _____

Doctor: _____

Witness: _____

Patient Acknowledgement of Receipt of Dental Materials Fact Sheet and Notice of Privacy Practices

As of January 1, 2002, the Dental Board of California now requires that we distribute to our patients, a copy of the Dental Materials Fact Sheet. In addition, the Health Insurance Portability and Accountability Act (HIPPA) 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.
(If you want a copy of either sheet, please inform the front desk personnel)

1. A copy of Dental Materials Fact Sheet, and
2. Notice of Privacy Practices

Patient or Guardian Signature

Date

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