We are complimented that you have selected us to provide dental care for you and your family.

Patient Information

Date _____ Patients Name _____

(Is patient a full time student, fill in school name) _____

Address _____

Home Phone _____ Birthdate _____ Social Security # _____

(If patient is a minor, give parent's or guardian's name) _____

Whom may we thank for referring you to our office? _____

Name of nearest relative not living with you _____

Complete Address _____ Phone _____

Email _____

Responsible Party Information

Name _____

Residence _____

Mailing Address _____

How long at this address? _____ Home phone _____ Work phone _____

Previous Address (if less than 3 years) _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Employed Address _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Employer Address _____

Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____

Insurance Co. Address _____ Ph. # _____

Is policy connected with your union? Yes ____ No ____ Name of Union _____ Local No. _____

Do you have dual coverage? Yes ____ No ____ If yes: Please complete the following secondary insurance information: _____

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Co. _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Ph. # _____

Insured's Employer _____ Ph. # _____

Dental Information

Do your gums bleed when you brush? Yes ____ No ____

Are your teeth sensitive to heat or cold? Yes ____ No ____ Pressure Yes ____ No ____ Sweets Yes ____ No ____

Do you grind or clench your teeth? Yes ____ No ____

Do you have any fear of dental work? Yes ____ No ____

Date of last dental examination _____ What was done at that time? _____

_____

How would you describe your current dental problem? _____

_____

How do you feel about the appearance of your teeth? _____

Please complete back page

Medical Information

1. Are you having pain or discomfort at this time? ..... YES NO
2. Have you been a patient in the hospital during the past two years? ..... YES NO
3. Have you been under the care of a medical doctor during the past two years? ..... YES NO

Physician's Name _____ Phone No. _____

Address _____

4. Have you taken any medication or drugs during the past two years? ..... YES NO
5. Are you now taking any medication or drugs? ..... YES NO

If yes, please list _____

6. Are you sensitive or allergic to any medication or anesthetics? ..... YES NO

If yes, please list _____

7. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure	YES	NO	Artificial Joints (hip, knee, etc.)	YES	NO	Allergy to Latex	YES	NO
Heart Disease or Attack	YES	NO	Kidney Trouble	YES	NO	Hepatitis B (serum)	YES	NO
Angina Pectoris	YES	NO	Ulcers	YES	NO	Venereal Disease	YES	NO
Congenital Heart Disease	YES	NO	Diabetes	YES	NO	A.I.D.S.	YES	NO
Heart Murmur	YES	NO	Thyroid Problems			H.I.V.	YES	NO
High Blood Pressure	YES	NO	Glaucoma	YES	NO	Cold Sores/Fever Blisters	YES	NO
Arteriosclerosis	YES	NO	Cancer	YES	NO	Blood Transfusion	YES	NO
Mitral Valve Prolapse	YES	NO	Emphysema	YES	NO	Hemophilia	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough	YES	NO	Anemia	YES	NO
Heart Pacemaker	YES	NO	Tuberculosis	YES	NO	Sickle Cell Disease	YES	NO
Heart Surgery	YES	NO	Asthma	YES	NO	Bruise Easily	YES	NO
Rheumatic Fever	YES	NO	Hay Fever	YES	NO	Yellow Jaundice	YES	NO
Arthritis	YES	NO	Allergies or Hives	YES	NO	Epilepsy or Seizures	YES	NO
Rheumatism	YES	NO	Sinus Trouble	YES	NO	Fainting or Dizzy Spells	YES	NO
Cortisone Medicine	YES	NO	Radiation Therapy	YES	NO	Nervousness	YES	NO
Drug Addiction	YES	NO	Chemotherapy	YES	NO	Tumors	YES	NO
Stroke	YES	NO	Hepatitis A (Infectious)	YES	NO	Developmentally Disabled	YES	NO
History of Bisphosphonates	YES	NO				History of Phen Fen	YES	NO

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest or shortness of breath, or because you are very tired? ..... YES NO
9. Do your ankles swell during the day? ..... YES NO
10. Do you use more than two pillows to sleep? ..... YES NO
11. Do you have or have you had any disease, condition, or problem not listed? ..... YES NO

If yes, please list: _____

FOR WOMEN ONLY:

Are you pregnant? ☐ Yes What month? _____ ☐ No Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Physician's Signature _____ Date _____

CONSENT AND APPOINTMENT POLICY:

1. The undersigned hereby authorizes doctor to take x-rays,study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.

2. I also authorized doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____ I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.

3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other a arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges.

4. I understand that where appropriate, credit bureau reports may be obtained.

5. I understand that it is my responsibility to advise your office of any charges in the information contained on this form.

6. **MINIMUM OF 24 HRS. IS REQUIRED TO CHANGE AN APPOINTMENT. IF THE OFFICE IS NOT NOTIFIED WITHIN THIS TIME PERIOD, YOU WILL BE SUBJECT TO A CANCELLATION FEE AS HIGH AS $25.00. APPOINTMENTS ARE CONFIRMED ONLY AS COURTESY. KEEPING APPOINTMENT IS SOLELY THE PATIENT'S RESPONSIBILITY.**

Patient: _____ Date: _____ Witness: _____

Patient or Responsible Party: _____ Relationship to Patient: _____

For Office Use Reviewed by Dr. _____ Date: _____

INFORMED CONSENT

PATIENT NAME_____ CHART NO._____

1.WORK TO BE DONE

I understand that I am having the following work done: Fillings ☐ Bridges ☐ Crowns ☐ Extractions ☐ Exam/Xray ☐
Impacted Teeth Removed ☐ Root Canals ☐ Dentures ☐ Partials ☐ Periodontics ☐ Other ☐

(Initials)_____.

2. DRUG AND MEDICATIONS

I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, vomiting, and/or anaphalactic shock (severe allergic reaction).

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the Dentist to make those changes as necessary.

(Initials)_____.

4. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crowns and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth_____.
and any others necessary under 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 risk 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 (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise d u ring or following treatments.

(Initials)_____.

5. ANESTHESIA

I realize the risks involved in receiving a local anesthetic, some of which are: partial facial paralysis, inflamed tissue, adverse reactions to drugs causing cardiac arrest, miscarriage; hemorrhage, nerve damage and/or numbness.

(Initials)_____.

6. CROWNS, BRIDGES AND CAPS

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, and that if I don't have the permanent crown(s) placed permanent serious damage or loss of the tooth/teeth involved my ensue, and that if I delay placement I may cause the teeth involved to move so that the permanent crown no longer will fit properly.

(Initials)_____.

7. DENTURES – COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing these appliances have been explained to me including looseness, soreness, and possible breakage, and relining due to tissue and bone change.

(Initials)_____.

8. 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 effect the success of the treatment, and that this treatment often requires multiple visits and that I can cause serious damage or loss of the tooth/teeth involved if I do not complete the prescribed treatment.

(Initials)_____.

9. PERIODONTAL LOSS (TISSUE AND BONE)

I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. The alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions.

(Initials)_____.

I hereby request and authorize the Dentists, and their Staff, to perform dental work upon me for the purpose of attempting to improve my appearance, function and the health of my mouth, teeth, bone and tissues, as explained above.

The effect and nature of the proceeding to be performed, and the risk involved, as well as the possible alternative methods of treatment have been fully explained to me.

I also authorize the operating Dentist and Assistants to perform any other procedure which they may deem necessary or desirable in attempting to improve the condition stated on the diagnostic treatment form, or treat unhealthy or unforeseen conditions that may be encountered during the operation.

I know that the practice of Dentistry and surgery 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 treatment which I have herein requested and authorized.

Alternatives and possible had reactions have been explained to me in detail. Complications, such as infection, hemorrhage and/or bleeding, scarring, contraction, possible deformities, prolonged healing time over the estimate, reaction to any drugs before, during and after surgery, numbness or itching of the tongue, lip, teeth, tissues (Parasthesia), fractured jaw, etc., have been clearly explained to me.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT AND THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE. ANYTHING I DID NOT UNDERSTAND HAS BEEN EXPLAINED TO ME.

Signature:_____ Date:_____
Patient or Legal Representative

Witness:_____ Date:_____

Doctor:_____ Date:_____

HIPAA Privacy Rule Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I _____ understand that as part of my health care, **Pasadena Family Dental Center** originates and maintains health records describing my heath history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the health professionals who may contribute to my health care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided;
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy and understand the ***Notice of information Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review **Pasadena Family Dental Center** notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

PHI Authorized:

Purpose Authorized:

Parties to whom my PHI is authorized to be released:

I understand that:

- I have the right to request restrictions as to how my health Information may be used or disclosed to carry out treatment, payment or healthcare operations by other covered entities.
- I may revoke this consent in writing at any time, except to the extent that **Pasadena Family Dental Center** has already taken action in reliance thereon. I understand that this action may limit my future treatment options.

_____ Accepted _____ Denied

Signature of Patient or Legal Representative Witness _____.

Printed Name of Patient or Legal Representative Witness _____. Date: _____