Patient Information (Confidential) **Date: _____**

Patient Name: _____ Preferred Name _____

Birthday: _____ **Soc. Sec #:** _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone:_____ Home Phone: _____

Employer: _____ Work #: _____

Business Address: _____ City: _____ State:_____ Zip:_____

Email Address: _____

Check Appropriate: Minor _____ Single____ Divorced ____ Widowed _____ Married _____

Who may we thank for referring you? _____

Spouse or Parent's Name: _____

Person to Contact in case of emergency: _____ Phone #: _____

Responsible Party

Name of Person Responsible for this Account: _____

Relationship to Patient: _____ Birthday: _____ Soc. Sec. #: _____

Cell Phone #: _____ Home Phone #:_____Driver's License #:_____

Employer: _____ Work Phone:_____

Is this Person Currently a patient in our Office? YES ☐ NO ☐

Primary Insurance Information

Name of Subscriber: _____ Birthday: _____

Relationship to Patient: _____ Soc. Sec. _____

Name of employer: _____ Work Phone:_____ Ext _____

Address: _____ City: _____ State: _____ Zip: _____

Ins. Company: _____ Group #:_____Subscriber ID# _____

Ins. Co. Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance Information

Name of Subscriber: _____ Birthday: _____

Relationship to Patient: _____ Soc. Sec. _____

Name of employer:_____ Work Phone:_____ Ext _____

Address: _____ City: _____ State: _____ Zip: _____

Ins. Company: _____ Group #:_____Subscriber ID# _____

Ins. Co. Address: _____ City: _____ State: _____ Zip: _____

MEDICAL HISTORY

Please list **ALL prescription medication, herbal products** and over **the counter products you are taking.** If you are taking any "street drugs" please list them. Any drug can interact with the medications we administer. Your medical information is private and you health is important.

Do you have any of the following? (Circle Yes or No)

Congenital Heart Defect	Yes	No	Rheumatic Fever	Yes	No	
Heart Murmur	Yes	No	Mitral Valve Prolapse		Yes	No
Joint Replacement	Yes	No	Heart Surgery		Yes	No

If yes, how long? _____ If yes, what type? _____

Antibiotic Pre-Medication- A "YES" answer to any of the above questions may require antibiotic pre-medication or a release form from your physician prior to any dental treatment.

If I require antibiotic pre-medication, I understand and agree it is my responsibility to take the prescribed antibiotics as directed before **ANY** dental procedure is performed. If I need another prescription for pre-medication I will ask. I understand that failure to take the antibiotic premedication can result in serious medical complications. **INITIAL:** _____

Diabetes	Yes	No	Asthma or Emphysema	Yes	No	
Heart Attack	Yes	No	Pacemaker	Yes	No	
Abnormal Bleeding	Yes	No	Hemophilia	Yes	No	
Cancer/Chemotherapy	Yes	No	Radiation Therapy	Yes	No	
Liver Disease/Hepatitis	Yes	No	Kidney Disease	Yes	No	
Epilepsy or Seizures	Yes	No	Stroke	Yes	No	
Blood Transfusions	Yes	No	HIV+ or AIDS	Yes	No	
Anemia	Yes	No	High / Low Blood Pressure	Yes	No	
Alcohol Use (2+daily)	Yes	No	Tuberculosis (TB)	Yes	No	
Tobacco Use	Yes	No	Thyroid Problems	Yes	No	
Sinus Problem	Yes	No	Herpes / Fever Blisters	Yes	No	

Are you ALLERGIC to any of the following?

Penicillin	Yes	No	Tetracycline	Yes	No	Erythromycin	Yes	No
Sulfa / Sulfides	Yes	No	Aspirin	Yes	No	Codeine	Yes	No
Dental Anesthetics	Yes	No	Jewelry / Metals	Yes	No	Latex	Yes	No

List any other allergies you may have_____

Are you pregnant (women)? Yes No Maybe

Are you under the care of a physician? Yes No
Name and telephone number of Physician: _____
If so, what condition being treated? _____

Have you taken any prescribed diet medication such as Phen-Fen? _____

Please explain any "yes" answers. Also, list any other medical conditions or limitations you may have that are not listed above:

I certify that the information given on this medical history form is correct and complete to the best of my knowledge. I also understand that complete, correct and up to date information is important for my wellbeing and safety. I understand and agree that it is my responsibility to inform this office of any changes in medical status before my treatment is rendered.

Patient Signature _____ Date _____
Print Name _____
Doctor: _____ Witness: _____

ACKNOWLEDGEMENT OF: RECEIPT OF NOTICE PRIVACY PRACTICES. (HIPAA)

The Health Insurance Portability and Accountability of Act of 1996 (HIPAA) requires that health care providers give patients a copy of the office Notice of Privacy Practices and make a good faith effort to obtain an acknowledgment of the receipt of same.
You may refuse to this acknowledgment form.

By signing this form I have received a copy of the Notice of Privacy Practice.

Patient's name: _____

Signature of Patient or guardian: _____ Date: _____

If minor: Relationship to patient_____

Written acknowledgment was not obtained

Patient Acknowledgment of Receipt of Dental Materials Fact Sheet

I, _____, acknowledge I have received from
(Patient Name)
Image Dental a copy of the dental Materials Fact Sheet dated October 2001.

_____ _____ _____
Patients or guardians Signature Date Relationship to patient

GENERAL DENTISTRY INFORMED CONSENT

PATIENT NAME: _____

1. **EXAM AND X-RAYS-** I understand that necessary x-rays are required in assisting the dentist provide and perform a comprehensive diagnostic dental exam.

(Initials_____)

2. **DRUGS AND MEDICATIONS-** I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock.

(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. For example, root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/ all changes as necessary.

(Initials_____)

4. **REMOVAL OF TEETH-** Alternative to removal has been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth_____ and any other necessary for reasons in paragraph # 3. I understand removing teeth does not always remove all the infection, if present, and it may necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, and 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 if complications arise during or following treatment, the cost of which is my responsibility.

(Initials_____)

5. **CROWNS, BRIDGES, AND CAPS**- I understand that sometimes it is not easy 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 and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap including shape, fit, size and color will be before cementation. **It is also my responsibility to return for permanent cementation within 30 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge or cap. I understand there will be additional charges for remakes due to my delaying permanent cementation.**

(Initial_____)

6. **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 root canal fillings material may extend through the root which does not necessarily affect the success of the treatment. I understand that occasionally instruments can become broken or separated during the endodontic procedure and that additional surgical procedures may be necessary following root treatment. I understand that the tooth may be lost despite all effort to save it.

(Initials_____)

7. **PERIODONTAL DISEASE AND BONE LOSS**– I understand that I have a serious periodontal condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth and other serious health conditions. Alternative treatment has been explained to me, including Scaling and Root Planing (Deep Cleaning), gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

(Initials_____)

8. **DENTURES AND PARTIALS-** I understand the wearing of dentures or partial dentures are difficult. Sore spots, altered speech and difficulty in eating are common problems. Immediate dentures (placement of dentures immediately after extraction) may be painful. Immediate dentures may require considerable adjusting and several relines. Permanent reline will be needed later. This is

not included in the fees. I understand that it is my responsibility to return for delivery of the dentures. **I understand that denture and partials require several dental appointments for impressions, try ins, and delivery of. Failure to keep any of these appointments may result in poorly fitted dentures or partials. If remake is required due to my delays for more than 30 days there will be additional charges.**

(Initials_____)

9. **FILLINGS:** I understand that care must be exercised in chewing on fillings especially during the first 24 hrs to avoid breakage. I understand that a more extensive filling that originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling.

(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 neither Dentist nor Dental Group of Stockton is responsible for my dental treatment.

I hereby authorize any of the doctors or dental auxiliaries of Image Dental to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending in unforeseen or undiagnosable that may arise during the course of treatment. **I understand that regardless of any dental insurance coverage I may have, I am responsible for payment dental fees. I agree to pay any attorney's fees, collection fees, or court that may be incurred to satisfy this obligation.**

Should any dispute arise over dental services provided to me, that is whether any dental service rendered allegedly unnecessary, unauthorized or was improperly, negligently, or incompetently performed, said disputes shall be submitted to Peer Review by the local component of The American Dental Association. The decision of Peer Review photocopy of this authorized shall be as valid and effective as the original forever I am of legal age and legally competent to make this assignment.

Signature: _____ Date: _____

Doctor: _____ Witness: _____

Office Policy

1. The doctor's time is very valuable, therefore we reserve the right to charge a $35 per hour fee for any missed (broken) or cancelled appointments with a less than 24 hour notice.

2. For appointments scheduled with the Specialist (Oral Surgeon, Endodontist, ect) we will charge a $75.00 per hour fee for any missed, broken, or cancelled appointments if less than a 72 hour notice is given.

3. If you wish to obtain a copy of your records, you must request the records in writing. There's a $25 charge for duplication of any x-rays and a $45 charge for x-ray/record duplications.

4. We do our best to provide you with an accurate estimate for your treatment. However, you are ultimately responsible for any co-pays and/or outstanding and unreimbursed balance on your account.

5. If the doctor discusses diagnosis of your treatment and you refuse to abide by it, by law we cannot go against the doctor's diagnosis.

6. We reserve the right to change the above policies without notice.

By signing below, you understand the above policies.

_____ _____

Patient Signature Date

_____ _____

Parent/Guardian Relationship