James P. Toner, DDS
17542 Irvine Blvd., Suite C
Tustin, CA 92780
www.TonerSmiles.com
714-544-8000

WELCOME TO OUR DENTAL PRACTICE!

Let me take this time to welcome you to our practice on behalf of myself and my staff. We appreciate that you have selected out dental team to provide you with excellent dental health. We take pride in and are committed to providing you quality oral health in a comfortable, gentle, and professional environment.

During your initial visit, a thorough examination will be performed. It will include the appropriate digital x-rays , complete oral exam, and an oral cancer screening.

We strive to maintain and retain the health of your natural teeth. By working together to develop a mutual understanding and clarify our expectations of one another, we will reach that goal. I strongly encourage you to inquire at any time about any aspect of your treatment plan.

Enclosed you will find our patient health questionnaire. Please complete this form and bring it to your first visit. If you have dental insurance, please bring your benefit information.

Best Regards,

James P. Toner D.D.S.

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OFFICE POLICIES AND FINANACIAL AGREEMENT

It is our desire to make high quality dental care affordable to everyone. The following is a statement of Our office policy and financial policy, which we ask that you read, agree to, and sign before any treatment is rendered.

Most dental insurances have limits and/or various degrees of co-payments. The treatment recommended by my office is never based on what your insurance will pay; your treatment **should not** Be governed by your insurance contract.

My office will gladly submit your insurance claim to your insurance carrier, as a courtesy to you. At the time of treatment the patient/guarantor is responsible for the portion the insurance does not cover. Please be aware that some insurance companies may not cover all services performed in my office. The patient/guarantor is responsible for all charges that are denied or unpaid by your insurance carrier. If for some unforeseen reasons your insurance carrier has not make payment within 90 days, the patient/guarantor is responsible for these charges.

Minors

The adult accompanying a minor is responsible for full payment. For unaccompanied minors, treatment will be denied, unless treatment and the charges have been pre-authorized by the parent or legal guardian.

*****Cancellation Policy*****

If you are unable to keep an appointment, we ask that you kindly provide us with a minimum of two (2) business days notice. Please call during business hours rather than leaving a voicemail after hours. This courtesy on your part will make it possible to give your appointment to another patient who needs to see the dentist or hygienist.

Regarding Insurance

If the patient has any insurance charges or maxes out of benefits, it is the patients/guarantor's responsibility to be aware of it and provide the information. If this information is not provided at the time of service the patient/guarantor will be responsible for the charges incurred.

I understand my dental insurance is a contract between the insurance carrier and the patient, not between doctors and insurance carrier. Please note that NO individual in the office can predict exactly what amount your insurance will pay. When we verify your coverage with your insurance company, they also indicate that there is no guarantee of coverage, until they receive the claim. We will only be able to give you an estimate and we cannot be held responsible to that estimate any way. In some cases, insurance companies use alterative benefits as a method of payment and not pay the total estimated amount. Therefore, do not hold us responsible for payments that a third party may refuse to pay.

Initial_____

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OFFICE POLICIES AND FINANCIAL AGREEMENT

Past-Due Accounts

I understand that I am financially responsible for all charges incurred in full by myself and/or my dependents. I agree that in the event my account is past due in excess of ninety (90) days from the date of service, it may be turned over to a collection agency unless arrangements are made in advance. Monthly interest rate of 1.5% (18% APR) may be incurred for accounts ninety (90) days past-due. I agree that I am liable for all collection charges including but not limited to attorney and legal fees in the event my account was turned over to collection agency.

A fee of $30.00 will be charged on all returned checks.

Managed Care Plans

I do not participate in any managed care, HMO, or DMO plans.

Insurance Signature Authorization

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me and my dependent and/or other health practitioners relating to all claims for benefits submitted on behalf of myself and/or dependents. I agree and acknowledge that my signature on the document authorizes my dentist to submit claims for benefits, for services rendered, or for services to be rendered, without obtaining my signature on each and every claim submitted for myself and/or my dependents. I will be bound by this signature as though I had personally signed each claim. I hereby assign all medical, dental, and/or surgical benefits to which I am entitled for this service to Dr James Toner. A photocopy of this assignment is to be considered as valid as an original.

Authority To Treat

I give Dr. James Toner the authority to administer dental x-rays, local injections, anesthetics, and if requested, a tranquilizer in the subsequent treatment of my case. If I have a medical condition, that requires premedication, or any drug allergy, I acknowledge that it is my responsibility to inform and remind the Doctor, Assistant, or the Hygienist every time before treatment. Please advise my office of ANY and ALL medications you may be taking – especially any blood thinners (Aspirin on a daily basis or Coumadin).

I have read, understand, and agree to the above Office Policies and Financial Agreement.

_____
Patient Name

_____
Patient Signature (parent or legal guardian if patient is a minor)

_____
Date

_____
Email Address:

Is it OK to contact/confirm appointments by email? ☐ Y ☐ N

Welcome

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 ABOUT YOU

Today's Date:_____

E-mail Address: _____

Name: _____
Last First Mi Mr Mrs Ms Dr

I prefer to be called:_____ ☐ Male ☐ Female

Birthdate:____/____/____ Age: ____ SS#: _____

Home Address: _____
Apt/Condo #

_____
City State Zip

☐Single ☐Married ☐Partnered ☐Divorced/Separated ☐Widowed

Hm #: (____)_____ Cell #: _____

Wk #: (____)_____ Ext:____ DL #: _____

Employer: _____

Employer's Address:_____

_____
City State Zip

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us:_____

Previous / Present Dentist:_____
(Please Circle)

Person Responsible for Account:_____

2 INSURANCE

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name:_____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #):_____

Insured's Name:_____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's ID #:_____

Insured's Employer: _____

Employer's Address:_____

_____
City State Zip

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name:_____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #:(____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name:_____ Relation: _____

Insured's Birthdate:____/____/____ Insured's ID #: _____

Insured's Employer: _____

Employer's Address:_____

_____
City State Zip

3 SPOUSE INFORMATION

His / Her Name:_____

Employer:_____

Wk #: (____)_____ Ext:____ SS #:_____

Birthdate:____/____/____ DL #: _____

Relative or Friend not living with you (for emergency).

His / Her Name:_____ Relation: _____

Wk #: (____)_____ Hm #: (____) _____

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____
Signature Date

CONTINUED ON BACK

4 MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: (____)_____ Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription / over-the-counter drugs? ☐ Yes ☐ No

Please list each one: _____

Have you ever taken Phen-Fen? (Also known as Redux or Pondimin) ☐ Yes ☐ No

If so, when? _____

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems

Y	N	Abnormal Bleeding / Hemophilia	Y	N	Herpes / Fever Blisters
Y	N	AIDS	Y	N	High Blood Pressure
Y	N	Alcohol / Drug Abuse	Y	N	HIV +
Y	N	Anemia	Y	N	Hospitalized for Any Reason
Y	N	Arthritis	Y	N	Kidney Problems
Y	N	Artificial Bones / Joints / Valves	Y	N	Liver Disease
Y	N	Asthma	Y	N	Low Blood Pressure
Y	N	Blood Transfusion	Y	N	Lupus
Y	N	Cancer / Chemotherapy	Y	N	Mitral Valve Prolapse
Y	N	Colitis	Y	N	Pacemaker
Y	N	Congenital Heart Defect	Y	N	Psychiatric Problems
Y	N	Diabetes	Y	N	Radiation Treatment
Y	N	Difficulty Breathing	Y	N	Rheumatic / Scarlet Fever
Y	N	Emphysema	Y	N	Seizures
Y	N	Epilepsy	Y	N	Shingles
Y	N	Fainting Spells	Y	N	Sickle Cell Disease / Traits
Y	N	Frequent Headaches	Y	N	Sinus Problems
Y	N	Glaucoma	Y	N	Stroke
Y	N	Hay Fever	Y	N	Thyroid Problems
Y	N	Heart Attack / Heart Surgery	Y	N	Tuberculosis (TB)
Y	N	Heart Murmur	Y	N	Ulcers
Y	N	Hepatitis	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Penicillin
Y	N	Codeine	Y	N	Jewelry/Metals	Y	N	Tetracycline
Y	N	Dental Anesthetics	Y	N	Latex	Y	N	Other

Please list any other drugs/materials that you are allergic to: _____

_____

5 DENTAL HISTORY

Why have you come to the dentist today? _____

_____

Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you floss daily? ☐ Yes ☐ No Brush daily? ☐ Yes ☐ No

Type of bristles on your toothbrush? ☐ Hard ☐ Medium ☐ Soft

Have you ever had gum treatment? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No Ever Itch? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Are your teeth sensitive to heat, cold, or anything else? _____

Do you have any loose teeth? ☐ Yes ☐ No

Do you still have wisdom teeth? ☐ Yes ☐ No

Would you like fresher breath? ☐ Yes ☐ No Whiter teeth? ☐ Yes ☐ No

Are you happy with the way your smile looks? ☐ Yes ☐ No

If not, what would you change? _____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

_____

Signature Date

OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information with the patient named herein.

Initials: _____ Date: _____

Doctor's Comments: _____

_____

_____

_____

_____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

MEDICAL HISTORY UPDATE

Has there been any change in your health status since your last visit? Y N

If Yes, please explain. _____

Has there been any change in your health status since your last visit? Y N

If Yes, please explain. _____

_____
Patient Signature Date

_____
Dentist Signature Date

_____
Patient Signature Date

_____
Dentist Signature Date