THANK YOU FOR SELECTING OUR DENTAL TEAM

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

PATIENT INFORMATION (CONFIDENTIAL) **Date_____**

First Name_____ Middle Initial _____ Last Name _____
Birth date_____ Age _____ □ Male □ Female
Check Appropriate Box: □ Minor □ Single □ Married/Partnered □ Separated/Divorced □Widowed

Home Phone_____ Cell Phone_____
Address_____
City_____ State_____ Zip_____
Email_____
Employer_____ Work Phone_____
Address_____ City_____ State_____ Zip_____

Whom May We Thank for Referring You?_____
Person to Contact in Case of Emergency_____Phone_____

RESPONSIBLE PARTY
Person Responsible for this Account_____ Relationship to Patient_____
Birth date_____
Address_____
City_____ State_____ Zip_____
Home Phone_____ Cell Phone _____Work Phone_____
Is This Person Currently a Patient in Our Office? □Yes □ No

INSURANCE INFORMATION □ not covered by dental insurance

Name of Insured_____ Relationship to Patient_____
Birthdate_____ SS#_____

Primary Insurance Company_____ Phone Number_____
Grp#_____ Policy ID#_____

Secondary Insurance Company_____ Phone Number_____
Grp#_____ Policy ID#_____

Patient Name: _____

PATIENT DENTAL HISTORY

REASON FOR THIS VISIT_____

WHEN WAS YOUR LAST DENTAL VISIT_____WHAT WAS DOEN THEN _____

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN_____

PREVIOUS DENTIST (NAME & LOCATION)_____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL X-RAYS TAKEN (WHEN & WHERE)_____

HOW OFTEN DO YOU BRUSH YOUR TEETH_____ HOW OFTEN DO YOU FLOSS YOU TEETH _____

	YES	NO
Do your gums bleed while brushing or flossing…….....□	□	
Are your teeth sensitive to hot or cold liquids/foods…….□	□	
Are your teeth sensitive to sweet or sour liquids/foods..□	□	
Do any of your teeth feel painful..... □	□	
Do you have any sores or lumps in or near your mouth…□	□	
Have you had any head, neck, or jaw injuries……..……□	□	
Have you experienced any of the following problems		
Clicking in your jaw.....□	□	
Pain (joint, ear, side of face)……..□	□	
Difficulty in opening or closing your jaw……..□	□	
Difficulty in chewing……..□	□	
Do you have frequent headaches……□	□	
Do you clench or grind your teeth……□	□	

	YES	NO
Do you bite your lips or cheeks frequently……□	□	
Have you noticed any loosening of your teeth……..……□	□	
Does food tend to become caught between your teeth…… ……□	□	
Have you ever had periodontal treatment (gums)…….……□	□	
Have you ever worn a bite plate or other appliance……□	□	
Have you had any difficult extractions in the past…….……□	□	
Have you ever had any prolonged bleeding following Extractions……..……□	□	
Do you wear dentures or partials……..……□	□	
If yes, give the date they were placed _____		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums……..……□	□	

IF YOU COULD CHANGE ANYTHING ABOOUT YOUR SMILE, WHAT WOULD YOU CHANGE?

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

_____ _____

SIGNATURE OF PATIENT OR PARENT/ GAURDIAN IF MINOR **DATE**

_____ _____

Patient Name: _____

MEDICAL HISTORY

Are you under the care of a physician/or other health care provider? Yes No
If yes please explain:_____
Physician/Health Care Provider Name:_____
Phone Number:_____

1. Have you ever had any of the following diseases/conditions?

High Blood Pressure	Yes	No
Heart Murmur	Yes	No
Heart Arrhythmias	Yes	No
Artificial Heart Valve	Yes	No
Mitral Valve Prolapse	Yes	No
Heart Attack When:	Yes	No
Heart Pacemaker	Yes	No
Stroke	Yes	No
Rheumatic Fever	Yes	No
Prosthetic Joints	Yes	No
Arteriosclerosis	Yes	No
Circulatory Problems	Yes	No
Kidney Disease or Infection	Yes	No
Hepatitis, Liver Disease, Jaundice	Yes	No
Anemia or Blood Disorders	Yes	No
Abnormal Bleeding Problem	Yes	No
AIDS, HIV Positive	Yes	No
Herpes, Cold Sores, Fever Blisters	Yes	No
Cortisone Medication	Yes	No
Organ Transplant	Yes	No
Eating Disorders (Anorexia, Bulimia, Etc.)	Yes	No
Convulsions, Fainting Spells, Epilepsy, Seizures	Yes	No
Glaucoma	Yes	No
Diabetes	Yes	No
Asthma, Hay Fever, Hives	Yes	No
Allergies	Yes	No
Skin Disease	Yes	No
Tuberculosis	Yes	No
Emphysema or Chronic Bronchitis	Yes	No
Thyroid or Parathyroid Disease	Yes	No
Stomach or Intestinal Ulcers	Yes	No
Cancer	Yes	No
Tumor or Growth	Yes	No
Radiation Therapy, Chemotherapy	Yes	No
Lymes Disease	Yes	No
Sinus Problems	Yes	No
Yeast, Candida, Fungus	Yes	No
Chronic Fatigue	Yes	No
Fibromyalgia	Yes	No
Auto-Immune Disease	Yes	No
Lupus, Multiple Sclerosis	Yes	No
Arthritis, Joint Pain, Gout	Yes	No
Mental Dysfunction or Psychiatric Therapy	Yes	No

2. Are you allergic to or have you reacted adversely to any medications?

Yes	No	***Penicillin or Amoxicillin***
Yes	No	Sulfa
Yes	No	Aspirin
Yes	No	***Narcotics (Codeine, Demerol, etc.)***
Yes	No	Iodine
Yes	No	Dental Anesthetics (Novocain)
Yes	No	***Latex***
Yes	No	***Acrylic***
Yes	No	Metals

Others:_____

3. Are you or have you taken any bone density medication? Yes No
If Yes, name of Medication:_____
4. Have you ever taken any of the drugs known as "Fen-phen"? Yes No

5. Do any of the following apply to you?

Yes	No	Frequently ill
Yes	No	Often exhausted or fatigued
Yes	No	Short of breath on mild exertion
Yes	No	Glasses or Contact lenses
Yes	No	Thirsty most of the time
Yes	No	Numbness or tingling in any part of your body
Yes	No	Experience fainting
Yes	No	Frequent or severe headaches
Yes	No	Pain in Jaw Joints
Yes	No	Chew tobacco
Yes	No	Smoke regularly
Yes	No	Drink coffee or tea regularly
Yes	No	Drink alcoholic beverages regularly
Yes	No	Have you had a physical in the last year
Yes	No	Has your general health changed the last year
Yes	No	Have you ever been hospitalized/surgeries

Please explain:_____

Yes	No	**Women**-are you pregnant at the present time
Yes	No	**Women**-are you breastfeeding at this time

6. Do you have any disease, or condition not listed?
if Yes Explain:_____

7. Are you aware of any specific toxic exposures that may have affected your health? _____

8. Are you taking any medications, drugs, pills, or supplements?
If yes, please list item and dosage: *(use back of page if necessary)*

Name	Dosage	Purpose

Patient Signature:_____
Date:_____
To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the dentist at the next appointment without fail.

UPDATE SECTION (For Future Use)

Date	Medication	Condition

Patient Name: _____

Office Policies Consent *(Please read carefully and initial consent on each line)*

Privacy Policy (HIPAA)
We strive to maintain your privacy and do not share records without your permission. We reserve the right to make changes to our policies; updated copies are always available for you online or in the office. Initials_____

Payment Policy
Pacific Dental Excellence has a general policy that payment is due and payable at the time of treatment. Professional services are charged directly to the patient and the patient is solely and personally responsible for payment. For your convenience we accept cash, check, all major credit cards, and have outside financing available.
Please Note: the cost of dental treatment, even with insurance, can be in the hundreds or even thousands of dollars. Our office has made arrangements with CareCredit and Lending Club to help you get the treatment you need now with payment plans you can afford. These accounts must be approved prior to treatment. Initials_____

Balances over 60 days will incur an interest charge of 1.5% per month and after 90 days, an additional $10.00 rebilling fee per statement will be charged. Returned checks will have an additional fee of $35.00 added to the amount of the returned check. Please contact the office manager for more information on any of the above payment options. Payment is expected within 10 days after the statement date. Initials_____

Insurance
We are happy to bill both your primary and secondary insurance carriers as a courtesy for our patients. Please understand that each patient is ultimately responsible for the cost of services rendered. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our financial relationship is with you, not your insurance company.
1. All charges are your responsibility whether your insurance company pays or not. Not all services are covered benefits in all contracts.
2. If the insurance company does not pay your balance in full within 30 days, we will ask that you contact the carrier to help speed things up.
3. If the insurance company does not pay in full within 60 days, we will require you to pay the balance due.
4. We will do our best to estimate insurance coverage and patient portions due (we will send pre-estimates for services over $300 at your request. If the insurance company does not pay the full amount anticipated, the patient is responsible for the difference. Initials_____

Appointments
Office visits are by appointment only. Appointments can be scheduled by telephone at (805) 929-6814 during regular office hours. Should you find that you have a conflict we will be happy to reschedule you at a later date, however we cannot guarantee prompt rebooking. Please give us at least 48 hours' notice of cancellation to avoid fees. Initials_____

Cancellations/ No Shows
All scheduled appointments will receive a courtesy phone call or text message 72-48 hours prior to your appointment. It is important that our office has current phone numbers and addresses at all times. It is important that our office has current phone numbers and addresses at all times. Ultimately, it is your responsibility to keep track of your appointments that you have scheduled. Patients who miss their appointment or cancel with less than 48 hours' notice prior to the appointment will be charged at a rate of $200.00 per hour scheduled. Unlike most dental offices, at Pacific Dental Excellence we do not book multiple appointments at the same time. That means your missed appointments could have gone to another patient and our staff could have been providing quality dental care. Thank you for understanding.
We understand that sometimes last minute cancellations are unavoidable. Individual circumstances may be discussed with the office manager and/or the dentist. Initials_____

Refunds and Credits
All refund requests must be submitted in writing to the office for consideration. Any available refunds will be issued within two weeks of the office receiving the request in the form of the original payment. Cash refunds will be issued by check only.
Please understand this office will not consider any refunds for completed treatment. If a patient decides to discontinue treatment after it has been started, a full refund will not be given. Individual circumstances may be discussed with the office manager and/or the dentist. In the event of a refund the patient will be responsible for any of the fees incurred by the office for treatment and/or financing.

In the case of overpayment or changes to treatment causing a credit to an account, we are happy to either refund the patient their paid portion, or leave a credit on the account to be applied towards future treatment. Initials_____

Patient's Signature: _____ *Date:* _____

Patient Name: _____

General Consent for Treatment

I understand that the practice of dentistry is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of my treatment. I recognize that long term success depends upon my cooperation and routine maintenance. I understand and accept that the consequences if no treatment is administered may include but are not limited to: infection, decay, and the need for additional restorations.

I authorize the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a diagnosis of my dental needs. I also authorize the Doctor to provide any and all forms of treatment, medication and therapy that may be indicated as we mutually agree upon them.

I understand that there are substantial risks and consequences that may be associated with any surgical, dental, diagnostic, or anesthetic procedure. I understand that not every conceivable hazard can be listed, but that the following possibilities exist, however infrequent or rare:

> Damage to adjacent teeth or fillings, Post-operative infection, Swelling, bruising or sensitivity, Infection, Allergic reactions to medications, or anesthesia, or Complications during treatment necessitating additional treatment or referral to a specialist.

Unforeseen conditions may arise during the procedure that requires a different procedure than set forth. I therefore authorize the doctor and any associates to perform such procedures when, in their professional judgment, they are necessary.

I understand that any medications, drugs, anesthetics, and prescriptions taken for my procedure may cause drowsiness and lack of awareness and coordination. I also understand that I should not consume alcohol or other drugs because they can increase these effects. I have been advised not to work and not to operate any vehicle, automobile, or hazardous devices while taking such medications and until fully recovered from their effects.

Patients may require local anesthesia for their comfort during the performance of dental restorations or surgical procedures. Your dentist will recommend and explain to you which type of anesthesia might be appropriate for your individual medical/dental needs.

Female patients: Because anesthetics, medications and drugs may be harmful to the unborn child and may cause birth defects or spontaneous abortion, every female must inform the dentist if she could be or is pregnant. Anesthetics, medications and drugs absorbed in the mother's milk may temporarily affect the behavior of the nursing baby. In either case, the anesthesia and treatment may be postponed.

Ozone Therapy: Dental/Medical Ozone Therapy is used in this office to treat conditions that involve bacteria, virus, fungal, and parasite infections. This dental therapy can be applied externally or through injection. As with any injection there are risks of pain, bruising, and blisters at the injection site. Dental Ozone has clinically been observed to increase circulation, oxygenation, and improved immune response in clinical dental application. The use of Ozone has been in the United States since 1885. The FDA has not reviewed or approved statements made regarding the effective use of medical/dental ozone in clinical treatment. Results in treatment may vary and no claims are being made in the specific treatment for any condition for any particular reason.

I acknowledge and understand the above information provided herein is correct and <u>I will give any updates regarding my personal or medical history as needed</u>. I will ask any and all of my questions regarding my treatment, including my alternative forms of treatment, the advantages and disadvantages of each, and have my questions regarding fees answered. I give permission for the doctor to proceed with examinations, diagnosis, and treatment as needed.

Patient's Signature: _____ *Date:* _____