DR. JUAN ANGULO
41680 IVY STREET, SUITE C
MURRIETA, CA 92562

PATIENT NAME _____ SSN _____

ADDRESS _____

CITY_____ ST _____ZIP.

HOME PHONE# CELL PHONE#

RECEIVE TEXT MESSAGES REGARDING YOUR APPOINTMENT: YES OR NO

BIRTHDATE _____ MALE_____ FEMALE.

E-MAIL ADDRESS:_____

MINOR SINGLE DIVORCED SEPERATED MARRIED WIDOWED

PATIENT'S EMPLOYER_____OCCUPATION

EMPLOYER ADDRESS _____ __

EMPLOYER PHONE NUMBER

SPOUSE'S NAME _____ BIRTHDATE.

SSN SPOUSE'S EMPLOYER

IN CASE OF EMERGENCY, CONTACT _____

PHONE NUMBER ADDITIONAL NUMBER

WHOM MAY WE THANK FOR REFERRING YOU

DO YOU HAVE DENTAL INSURANCE: YES OR NO

NAME OF POLICY HOLDER_____RELATION TO PATIENT
BIRTHDATE _____ SSN / ID #_____
NAME OF EMPLOYER_____
NAME OF INSURANCE COMPANY _____
GROUP#_____ADDRESS_ _____
PHONE NUMBER TO INSURANCE _____

HIPPA PRIVACY RULE CONSENT, INFORMATION DISCLOSURE. AND INSURANCE AUTHORIZATION ALL INFORMATION PROVIDED BY THE PATIENT. IS DEEMED PRIVATE UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA) AND WILL BE USED AS FOLLOWS ONLY WITH THE PATIENT CONSENT. I HEREBY AUTHORIZE DR. JUAN ANGULO TO FURNISH INFORMATION TO OTHER PROVIDERS. HEALTH CARE TREATMENT FACILITIES. AND MY INSURANCE COMPANIES FOR PURPOSE OF TREATMENT. PAYMENT. AND HEALTH CARE OPERATIONS. I HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR DENTAL SERVICES RENDERED TO MYSELF AND/OR MY DEPENDANTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

Juan Angulo D.D.S.

General & Cosmetic Dentistry

41680 Ivy Street, Suite C
Murrieta, CA 92562

Patient Name:

Have you been under the care of a medical doctor during the past two years: Yes No
If yes, for what? _____
Physician's Name: _____
Last Visit to Physician: _____
Do you have high blood pressure? Yes No
Do you use tobacco? Yes No
Are you currently taking any medications? Yes No

List Medications:

Are you allergic or have you had a reaction to the following....

Local Anesthetic	Yes No
Penicillin or Other Antibiotics	Yes No
Aspirin, Ibuprofen or Tylenol	Yes No
Codeine, Valium or Other Sedatives	Yes No
Latex or Metals	Yes No

Have you ever had an allergic or adverse reaction to any medication or substance (including foods) Yes No -

If yes, please list:

Circle yes or no to indicate whether or not you have had or now have the following conditions or treatments:

Heart Condition	Yes No	Contact Lenses	Yes No	Cortisone Medicine	Yes No
Heart Attack	Yes No	Glaucoma	Yes No	Arthritis	Yes No
Heart Surgery	Yes No	Bruise Easily	Yes No	Fen-Phen or Redox	Yes No
Chest Pain (Angina)	Yes No	Emphysema	Yes No	Special Diet	Yes No
Congenital Heart Disease	Yes No	Chronic Cough	Yes No	Latex Sensitivity	Yes No
Stroke	Yes No	Tuberculosis	Yes No	Cancer	Yes No
High Blood Pressure	Yes No	Asthma	Yes No	Tumors	Yes No
Mitral Valve Prolapse	Yes No	Hay Fever	Yes No	Chemotherapy	Yes No
Artificial Heart Valve	Yes No	Sinus Trouble	Yes No	Radiation Therapy	Yes No
Rheumatic Fever	Yes No	Allergies/Hives	Yes No	Neurological Disorder	Yes No
Heart Murmur	Yes No	Liver Disease	Yes No	Nervous/Anxious	Yes No
Heart Pacemaker	Yes No	Hepatitis Type	Yes No	Epilepsy/Seizures	Yes No
Anemia	Yes No	Yellow Jaundice	Yes No	Fainting/Dizzy	Yes No
Hemophilia	Yes No	Aids	Yes No	Psychiatric Care	Yes No
Ulcers	Yes No	HIV Positive	Yes No	Kidney Trouble	Yes No
Alcoholism	Yes No	Artificial Joints	Yes No	Drug Addiction	Yes No
Venereal Disease	Yes No	Cold Sores	Yes No	Sickle Cell Disease	Yes No
Diabetes	Yes No	Osteoporosis	Yes No	Thyroid Problems	Yes No
Blood Transfusion	Yes No	Bone Disease	Yes No	Bone Cancer	Yes No
Swollen Ankles	Yes No				

Any disease, condition or problem not listed:

Women:
Are you pregnant or planning pregnancy? Yes No
If yes, due date: _____
Are you a nursing mother Yes No
Are you taking birth control pills Yes No

Signature: Date:
_____ Date:
Initial If There Are No Changes To Your Health History.

CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct the dentist Dr. Juan Angulo and/or dental auxiliaries of his choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.

    A. Preventative hygiene treatment, (prophylaxis) and the application of topical fluoride.
    B. Application of plastic "sealants" to the grooves of the teeth.
    C. Treatment of diseased or injured teeth with dental restorations (fillings and/or crowns).
    D. Replacement of missing teeth with dental prostheses, (bridges, partial dentures, full dentures).
    E. Removal (extraction) of one or more teeth.
    F. Treatment of diseased or injured oral tissues (hard and/or soft).
    G. Treatment of malposcd (crooked) teeth and/or oral developmental or growth abnormalities.

2. I understand that there are risks involved in this treatment and hereby acknowledge that these risks will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and

    „ that I fully understand the same.

3. I will be advised that the success of the dental treatment to be provided will require that the patient and/or parents of the patient follow post operative and post-care instructions of the dentist I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his auxiliaries must be maintained.

4. I.recognizc that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those disclosed. I therefore authorize and request the performance of any additional procedures that are deemed necessary are desirable to oral health and well being, in the professional judgement of the dentist.

5. There are possible risks and complications associated with the administration of local anesthetics, sedation, and drags. The most common of these arc swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face, and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip or check biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medication in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.

6. I authorize the dentist to use photographs, radiographs, other diagnostic materials and treatment records for the purpose of teaching, research and scientific publications.

7. 1 hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner, and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.

8. I further understand that this consent will remain in effect until such time that I choose to terminate it.

Date _____ Patients name:

Name of parent or guardian: _____

Relationship to patient: _____

Signature of patient or parent/guardian **Date**

DENTAL APPOINTMENT AGREEMENT

PURPOSE

Due to the large number of people who make appointments but fail to show up or fail to give adequate advance notice when canceling them, it has become necessary to have a policy on appointment responsibility. Broken and cancelled appointments waste the doctors, hygienists, and staffs very limited time and hinder the dental program's efforts to improve the oral health status of the people that we serve.

RESCHEDULING APPOINTMENTS

The dental staff understand that sometimes situations arise that require rescheduling of your appointment. If you need to reschedule, please call the dental office as soon as you know that you will not be able to keep the appointment, at least 24 hours before the appointment time.

BROKEN APPOINTMENTS

If you miss a scheduled appointment or cancel it at the last minute, a broken appointment will be recorded in your dental chart. If you are more than 15 minutes late for an appointment, a broken appointment will also be recorded, and you may have to be rescheduled if there is not enough time to complete your procedure. It is not fair to keep other patients waiting because someone showed up late.

If a broken appointment occurs (i.e. not giving 24 hour notice), a charge of up to $50.00 may be applied to a broken appointment. If more than (3) broken appointments have occurred, our office has the right to dismiss you as a patient.

Our office will try to call you the day before your dental appointment as a courtesy. On some occasions our office will not be able to extend this courtesy to you, so please do not rely on this phone call to remind you of your appointment. It is the patient's responsibility to remember the appointments.

Thank you for your cooperation and understanding of this matter!

Dr. Juan Angulo & Staff

X _____ , _____

Patient Name (Please **Print)** **Date**

X

Patient **or Guardian Signature**