WELCOME

Patient Information

Date_____ ID#/SS#_____

Patient_____

Address_____

_____

City State Zip

Sex: ☐ M ☐ F Age_____ Birthdate_____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation_____

Employer_____

Employer Address_____

Employer Phone (_____)_____

Spouse's Name_____

Birthdate_____ SS#_____

Occupation_____

Spouse's Employer_____

Whom may we thank for referring you?_____

_____

Dental Insurance

Who is responsible for this account?_____

Relationship to Patient_____

Insurance Co._____

Group #_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name_____

Birthdate_____ SS#_____

Relationship to Patient_____

Insurance Co._____

Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with_____ and assign directly to Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ _____

Relationship Date

Phone Numbers

Home(_____)_____ Work(_____)_____ Ext_____ Spouse's Work(_____)_____

Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name_____ Relationship_____

Home Phone (_____)_____ Work Phone (_____)_____

Dental History

Reason for today's visit_____

_____

Former Dentist_____

City/State_____

Date of last dental visit_____

Date of last dental X-rays_____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss?_____

How often do you brush?_____

Health History

Physician's Name_____ Date of last visit_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No		
Anemia	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No		
Arthritis, Rheumatism	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No		
Artificial Heart Valves	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No		
Artificial Joints	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No		
Asthma	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No		
Back Problems	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No		
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Hepatitis Type _____	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No		
Blood Disease	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No		
Cancer	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No		
Chemical Dependency	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No		
Chemotherapy	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No		
Circulatory Problems	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No		
Congenital Heart Lesions	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No		
Cortisone Treatments	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No		
Cough, persistent or bloody	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No		
Diabetes	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No		
		Pacemaker	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No		
		Psychiatric Care	☐ Yes ☐ No				

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date_____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Pharmacy Name_____

Phone (_____)_____

Allergies

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other_____

☐ Latex _____

Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?_____

Are you taking any new medications?_____ If so, what_____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

.....

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?_____

Are you taking any new medications?_____ If so, what_____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

DENTAL TREATMENT CONSENT FORM

Please read and initial the items checked below and read and sign the section at the bottom of form.

Patient Name_____

☐ **1. WORK TO BE DONE**

I understand that I am having the following work done: Fillings_____ Bridges_____ Crowns_____ Extractions_____ Impacted teeth removed _____ General Anesthesia_____ Root Canals_____ Other_____

(Initials_____

☐ **2. DRUGS AND MEDICATIONS**

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling o tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). (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 o the teeth that were not discovered during examination, the most common being root canal therapy following routine restorativ procedures. I give my permission to the Dentist to make any/all changes and additions 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 for reasons in paragraph #3. understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. understand the risks 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 (Paresthesia) that can last for an indefinite period of time (days or months) or fracture jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment the cost of which is my responsibility. (Initials_____

☐ **5. CROWN, 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. 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. (Initials_____)

☐ **6. 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. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. (Initials_____)

☐ **7. 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 affect the success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). (Initials_____)

☐ **8. PERIODONTAL LOSS (TISSUE & 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. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition. (Initials_____)

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully 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 have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient_____ Date_____

Signature of Parent/Guardian if patient is a minor_____ Date_____

Arbitration Agreement

ARTICLE 1

. It is understood that any dispute as to dental malpractice, that is, as to whether any dental services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

ARTICLE 2

. Parties To The Agreement. The term "Patient" as used n this Agreement includes the undersigned individual, iis or her spouse, children (whether born or unborn), ind heirs, assigns, or personal representatives. The ndividual signing this Agreement signs it on behalf of the oregoing persons, and intends to bind each of them to irbitration to the full extent permitted by law.

The term "Doctor" as used in this Agreement includes he undersigned doctor and his or her professional :orporation or partnership, and any employees, agents, uccessors-in-interest, heirs and assigns of the foregoing ndividuals or entities. The doctor signing this \greement signs it on behalf of all the foregoing ndividuals and entities, intends to bind each of them to rbitration to the full extent permitted by law.

). Treatment Covered. Patient understands and agrees hat any dispute of the sort described in Article 1 ietween Doctor and Patient will be subject to ompulsory, binding arbitration.

. Other Doctors (If Applicable). Patient understands iat he or she may at times receive treatment from one or iore doctors who practice jointly with the undersigned octor. It is understood and agreed that any dispute of ie sort described in Article 1 between Patient and such octors practicing with the undersigned doctor will be ubject to compulsory, binding arbitration.

. Coverage of Prenatal Claims (if Applicable). Patient nderstands and agrees that, if Doctor treats her during regnancy, any dispute of the sort described in Article 1 s to medical treatment rendered to or affecting the nborn child will be subject to compulsory, binding rbitration.

ARTICLE 3

a. Informal Resolution of Disputes. In the event Patient feels that a problem has arisen in connection with the medical care rendered by Doctor to Patient, Patient will promptly notify Doctor so that Doctor may have the opportunity to resolve the matter. Notice may be given orally or in writing, and shall stop the running of the statute of limitations for 90 days.

b. Method of Initiating Arbitration. If the dispute is not resolved by mutual agreement within 90 days, Patient may initiate arbitration by notifying Doctor to that effect and by designating an arbitrator to act on Patient's behalf. Within 20 days of receipt of such notice, Doctor will designate an arbitrator to act on Doctor's behalf. In the event that more than two parties participate, parties aligned with Patient shall select one arbitrator, and parties aligned with Doctor shall select a second arbitrator. The two "party" arbitrators shall select a neutral arbitrator. The controversy shall then be submitted to the three arbitrators for a final and binding decision.

c. Applicable Law. The arbitration shall be conducted pursuant to the California Arbitration Act (C.C.P. 1280-1296). The arbitrators shall, in addition, have authority to order such other discovery as they deem appropriate for a full and fair hearing of the case. A determination on the merits shall be rendered in accordance with the law of the State of California including the provisions of the Medical Injury Compensation Reform Act of 1975 which shall apply to the same extent as if the dispute were pending before a superior court of this State.

d. Interpretation of Agreement. Any controversy concerning the interpretation or application of thi Agreement itself shall also be submitted to arbitration in the manner provided above.

ARTICLE 4

Revocation. If you sign this Agreement and then change your mind, the law permits you to revoke the Agreement, providing you give your Doctor written notice within 30 days from signing that you want to withdraw from the Agreenment. However, doctor and Patient agree that any claim arising from dental sevices rendered prior to revocation shall be subject to arbitration.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

'atient's Name *(Please Print)*:_____

)ated:_____ Signed:_____

)ated:_____ Doctor:_____

DALE FAMILY DENTAL

4048 Dale Road Suite 203
Modesto CA 95356

ACKNOWLEDGMENT OF RECEIPT OF DALE FAMILY DENTAL *DENTAL MATERIALS FACT SHEET*

I, _____ acknowledge I have received from Dale Family Dental
Patient name

a copy of the ***Dental Materials Fact Sheet*** dated October 2001.

_____ _____
Patient's Signature Date

FOR DALE FAMILY DENTAL USE ONLY

We attempted to obtain written acknowledgement of receipt of Dental Materials Fact Sheet, but acknowledgement could not be obtained because:

- ____ Patient refused to sign
- ____ Communications barriers prohibited obtaining the acknowledgement
- ____ An emergency situation prevented us from obtaining acknowledgement
- ____ Other (Please Specify)

_____

_____

_____

DALE FAMILY DENTAL

4048 Dale Road Suite 203
Modesto CA 95356

ACKNOWLEDGEMENT OF RECEIPT OF DALE FAMILY DENTAL
NOTICE OF PRIVACY PRACTICES

I, _____ acknowledge I have received from Dale Family Dental
Patient name

a copy of the **NOTICE OF PRIVACY PRACTICE** as required by Federal Law.

_____ _____
Patient's Signature Date

FOR DALE FAMILY DENTAL USE ONLY

We attempted to obtain written acknowledgement of receipt of our notice privacy practice, but acknowledgement could not be obtained because:

- ___ Patient refused to sign
- ___ Communications barriers prohibited obtaining the acknowledgement
- ___ An emergency situation prevented us from obtaining acknowledgement
- ___ Other (Please Specify)

_____

_____

_____