



PATIENT INFORMATION

(This information is necessary for our files and will be considered **CONFIDENTIAL**)

Date _____

Patient's Name _____ Age _____ Patient's Birthday _____ Male Female
LAST FIRST INITIAL

If patient is a minor, give name of parent or legal guardian _____ Relationship _____

Residence Address _____ For how long? Own Rent
STREET CITY ZIP

Patient is: Married Single Divorced Separated Widowed Minor Email _____

Driver's License No. _____ Social Security No. _____ Res. Phone (_____) _____

Bank _____ Account No. _____ How long? _____ Cell Phone (_____) _____

Employed by _____ How long? _____ Occupation _____

Business Address _____ Bus. Phone (_____) _____
STREET CITY ZIP

Spouse's Name _____ Driver's License No. _____ Soc. Sec. No. _____

Employed by _____ How long? _____ Occupation _____

Business Address _____ Bus. Phone (_____) _____
STREET CITY ZIP

Name of nearest relative not living with you _____ Relationship _____

Complete Address _____ Res. Phone (_____) _____
STREET CITY ZIP I have no physician

Name of Physician _____ ADDRESS _____ CITY _____ TELEPHONE _____

Former Dentist _____ ADDRESS _____ CITY _____ TELEPHONE _____

Why are you changing dentists? _____

Purpose of Appointment _____ Do you wish to speak to the doctor privately? Yes No

Is this office visit for Emergency Dental Care? Yes No If yes, explain: _____

School Children Attend _____ Whom may we thank for referring you? _____

FINANCIAL INFORMATION

Person responsible for this account _____ Relationship _____ (_____) TELEPHONE _____

Address _____ CITY _____ ZIP _____ (_____) CELL PHONE _____
STREET

PREFERENCE OF PAYMENT: Cash on day of treatment Visa No. _____ EXPIRATION DATE _____

State Aid No. Mastercard No. _____ EXPIRATION DATE _____

Name of insurance company (primary insurance) _____

INSURED PERSON'S NAME _____ BIRTHDATE _____ RELATIONSHIP _____ SOCIAL SECURITY NO. _____

NAME OF GROUP DENTAL PLAN _____ GROUP NO. _____ PLAN NO. _____ NAME OF UNION _____ LOCAL _____

Name of insurance company (secondary insurance) _____

INSURED PERSON'S NAME _____ BIRTHDATE _____ RELATIONSHIP _____ SOCIAL SECURITY NO. _____

NAME OF GROUP DENTAL PLAN _____ GROUP NO. _____ PLAN NO. _____ NAME OF UNION _____ LOCAL _____

TERMS & CONDITIONS

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for in cash at the time services are performed.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy.

A service charge of 1½% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination.

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's and/or collection fees.

I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content:

Signed _____ Date _____

HEALTH QUESTIONNAIRE

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.

Please answer each question. Check the appropriate box and/or circle **Yes** or **No** where applicable. Example: Are you alive? **Yes** **No**

MEDICAL HISTORY

1. Are you in good health? **Yes** **No**
2. Date of last physical examination _____
3. Are you now under the care of a physician? **Yes** **No**
If so, what is the condition being treated? _____
4. Have you ever had any serious illness or operation? **Yes** **No**
If so, what illness or operation? _____
5. Have you ever been hospitalized? **Yes** **No**
If so, what was the problem? _____
6. Are you taking any medications, drugs or herbs? **Yes** **No**
If so, what? _____ What dosage? _____
7. Are you using any recreational drugs (marijuana, cocaine, etc.)? **Yes** **No** If so, what? _____
8. Have you ever been premedicated with antibiotics for your dental treatment? **Yes** **No**
9. Are you sensitive or allergic to any drugs or materials? Penicillin; Tetracycline; Sulfa Drugs; Aspirin; Codeine; Latex; Other **Yes** **No**
If Other, what drugs? _____
10. Do you have or have you had any of the following: (Please circle 'Y' for Yes or 'N' for No - answer all conditions):

<input type="checkbox"/> YN Anemia	<input type="checkbox"/> YN Implant (s)	<input type="checkbox"/> YN Head Injuries	<input type="checkbox"/> YN Drug Addiction	<input type="checkbox"/> YN Blood Transfusion	<input type="checkbox"/> YN Excessive Bleeding	<input type="checkbox"/> YN Osteoporosis
<input type="checkbox"/> YN Herpes	<input type="checkbox"/> YN Headaches	<input type="checkbox"/> YN Heart Failure	<input type="checkbox"/> YN Kidney Disease	<input type="checkbox"/> YN Joint Replacement	<input type="checkbox"/> YN Mitral Valve Prolapse	<input type="checkbox"/> YN X-Ray or Cobalt Treatment
<input type="checkbox"/> YN Stroke	<input type="checkbox"/> YN Glaucoma	<input type="checkbox"/> YN Scarlet Fever	<input type="checkbox"/> YN Chemotherapy	<input type="checkbox"/> YN Nervous Disorders	<input type="checkbox"/> YN High Blood Pressure	<input type="checkbox"/> YN Radiation Treatment of any kind
<input type="checkbox"/> YN Ulcers	<input type="checkbox"/> YN Tonsillitis	<input type="checkbox"/> YN Sinus Trouble	<input type="checkbox"/> YN Stomach Ulcers	<input type="checkbox"/> YN Tumors or Growths	<input type="checkbox"/> YN HIV Related Complex	<input type="checkbox"/> YN Venereal Disease (Syphilis, Gonorrhea)
<input type="checkbox"/> YN Diabetes	<input type="checkbox"/> YN Hemophilia	<input type="checkbox"/> YN Heart Murmur	<input type="checkbox"/> YN Angina Pectoris	<input type="checkbox"/> YN Allergies or Hives	<input type="checkbox"/> YN Respiratory Disease	<input type="checkbox"/> YN Acquired Immune Deficiency Syndrome (AIDS)
<input type="checkbox"/> YN Arthritis	<input type="checkbox"/> YN Cold Sores	<input type="checkbox"/> YN Liver Disease	<input type="checkbox"/> YN Mental Disorder	<input type="checkbox"/> YN Pain in Jaw Joints	<input type="checkbox"/> YN Epilepsy or Seizures	<input type="checkbox"/> YN TMJ (Temporomandibular Joint) Disorder
<input type="checkbox"/> YN Asthma	<input type="checkbox"/> YN Emphysema	<input type="checkbox"/> YN Blood Disease	<input type="checkbox"/> YN Thyroid Disease	<input type="checkbox"/> YN Artificial Prosthesis	<input type="checkbox"/> YN Psychiatric Treatment	<input type="checkbox"/> YN Sleep Apnea
<input type="checkbox"/> YN Cancer	<input type="checkbox"/> YN Rheumatism	<input type="checkbox"/> YN Heart Ailments	<input type="checkbox"/> YN Fainting Spells	<input type="checkbox"/> YN Sickle Cell Disease	<input type="checkbox"/> YN Hepatitis or Jaundice	<input type="checkbox"/> YN Snoring
<input type="checkbox"/> YN Seizures	<input type="checkbox"/> YN Chicken Pox	<input type="checkbox"/> YN Heart Attack	<input type="checkbox"/> YN Rheumatic Fever	<input type="checkbox"/> YN Cortisone Medicine	<input type="checkbox"/> YN Difficulty Swallowing	<input type="checkbox"/> YN Other _____
<input type="checkbox"/> YN Hay Fever	<input type="checkbox"/> YN Bruise Easily	<input type="checkbox"/> YN Cerebral Palsy	<input type="checkbox"/> YN Tuberculosis (T.B.)	<input type="checkbox"/> YN Allergies to Metals	<input type="checkbox"/> YN Congenital Heart Lesions	
11. Do you have any disease, condition or problem not listed that you think we should know about? **Yes** **No**
If so, what? _____
12. Do you wear a cardiac pacemaker, or have you had heart surgery? **Yes** **No**
13. Do you smoke? If yes, how much? Cigarettes Cigars Packs per day **Yes** **No**
14. Have you ever taken the drugs Fen-Phen, Redux or any diet drugs? **Yes** **No**
15. (Women) Are you pregnant? If so how many months? **Yes** **No**
16. (Women) Do you have any problems associated with your menstrual period? **Yes** **No**
17. (Women) Do you take any birth control medication or hormones? **Yes** **No**

DENTAL HISTORY

1. Have you ever had a local anesthetic (Novocaine, etc.)? **Yes** **No**
2. Have you ever had any unfavorable reaction from a local anesthetic? **Yes** **No**
3. Have you had any serious trouble associated with any previous dental treatment? **Yes** **No**
If so, explain? _____
4. How long since your last full mouth X-Rays? _____

	Weeks	Months	Years
--	-------	--------	-------
5. How long since your last dental treatment? _____

	Weeks	Months	Years
--	-------	--------	-------
6. Does dental treatment make you nervous? Slightly Moderately Extremely? **Yes** **No**
7. Would you desire to be pre-sedated? **Yes** **No**

I hereby acknowledge I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changes in any way. Patient refused / was unable to sign because _____

I have received a copy of the **Dental Materials Fact Sheet** as required by law.

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

A Date _____ Signature _____

Reviewed by _____ Lic. # _____ Date _____

- B UPDATE — Since your last visit A:**
1. Have you seen a medical doctor? **Yes** **No**
 2. Have you had a change in your medication? **Yes** **No**
 3. Have you had a change in your medical condition or had surgery? **Yes** **No**
- Please note changes in health since last visit. If no changes, please write "None"*

Date _____ Signature _____

- C UPDATE — Since your last visit B:**
1. Have you seen a medical doctor? **Yes** **No**
 2. Have you had a change in your medication? **Yes** **No**
 3. Have you had a change in your medical condition or had surgery? **Yes** **No**
- Please note changes in health since last visit. If no changes, please write "None"*

Date _____ Signature _____

REVIEWED BY	DO NOT WRITE IN THIS SPACE		
A	A	B	C
DATE	DATE _____		
B	B.P. / / /		
DATE	PULSE _____		
C	TEMP _____		
DATE	BY _____		

HEALTH QUESTIONNAIRE MUST BE CONTINUALLY UPDATED!

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

All services are rendered and accepted under the terms and conditions printed on the reverse hereof:

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Signed: _____ Date: _____ Relationship to Patient _____

SmileNOW Dental Group

Notice of Privacy Practices

This notice describes how your health information may be used, disclosed and how you can access this information. Please review it carefully.

- At **SmileNOW Dental Group**, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.
- The Law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.
- We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.
- We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.
- We may use your information to contact you. For example we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.
- In an emergency, we may disclose your health information to a family member or another person responsible for your care.
- We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization.
- You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.
- You have the right to know of any uses of disclosures we make with your health information beyond the above normal uses. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.
- You have the right to transfer copies of your health information to another practice. We will mail your files for you.
- You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.
- You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but we will be happy to include your statement in your file. If we agree to any amendment or change, we will not remove nor alter earlier documents, but will add new information. You have the right to receive a copy of this notice.
- If we change any of the details of this notice, we will notify you of the changes in writing. You may file a complaint with the Department of Health Human Services

Independence Avenue S. W., Room 509F
Washington, DC 20201

You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer, Blanca at (951) 735-7300.

Acknowledgement

I have received a copy of the **SmileNOW Dental Group** Notice of Privacy Practices.

Signature: _____

Date: _____

Print Name: _____

If signing as a parent or guardian, please note the name of the patient _____

GENERAL DENTISTRY

INFORMED CONSENT

CHART #: _____

NAME: _____

1. WORK TO BE DONE

I understand that I am having the following work done: Fillings _____, Crowns _____, Bridge _____, Extractions _____, Impacted teeth removed _____, Local Anesthesia _____, Root Canals _____, X-Rays _____, Other 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 (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 on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative 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. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I 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 (Parasthesia) that can last for an indefinite period of time (days or months) or fractured 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. CROWNS, 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 change 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 denture (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 properly guarantee result. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized.

Signature: _____

Date: _____

Doctor: _____

Witness: _____