



PATIENT INFORMATION

Date: _____

Patient: _____

Last name

First name

MI

Preferred Name

Social Security #: _____

Address: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____

Sex: M F Age: _____ Birthdate: _____

Employer: _____ Occupation: _____

Bus. Address: _____

Bus. Phone: _____

Emergency Contact: _____

Name

Phone number

Relationship

Address: _____

Who is responsible for the account: _____

Relationship to patient: _____

Name of Dental Insurance: _____ Group number: _____

Whom May we thank for referring you? _____

MEDICAL HISTORY

Physician's Name _____ Date of last Physical _____

Have you ever had any of the following? (check boxes that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hepatitis, Jaundice or Liver Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> "A.I.D.S." or other Immunosuppressive Disorders |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Chronic Diarrhea | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Allergies to Anesthetics | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Artificial Heart valve or joints | <input type="checkbox"/> Allergies to Medicine or Drugs | <input type="checkbox"/> Chemical Dependency |
| <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> General Allergies | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Swollen Neck Gland |
| <input type="checkbox"/> Special Diet | <input type="checkbox"/> Epilepsy | |

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____
 If so, what _____
 Have you ever responded adversely to medical or dental treatment? _____
 Are you taking medication at this time? ____ If so, what _____
 Are you under the care of a physician? Yes No
 For what conditions? _____
 If a patient is a child, what is his/her weight? _____
 (Women) Do you suspect that you are pregnant? Yes No Are you Nursing? Yes No
 Is there anything else we should know about your medical history? _____

APPOINTMENT: A minimum charge will be made for failed or canceled appointment without prior notification of 24 hrs. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you.

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT: I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statement, promptly upon presentment thereof, unless credit arrangement are agreed upon in writing. Should this account become past due, a finance charge of 1.5% per month of the remaining balance will be added until the account is paid in full. Charges shown by statements are agreed to be correct and reasonable unless protest received in writing within 30 days of the billing date. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such cost as the court determines proper.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection hereof. (A copy of this assignment is as valid as the original.)

NOTICE: Do not sign this agreement before you read and agree to the conditions set forth. You are entitled to a copy of this agreement at the time you sign. Keep it to protect your legal rights.

AGREEMENT: The above information is for the purpose of obtaining credit and is warranted to be true. I authorize the creditor investigation.

Signature: _____ Date: _____
 Dr. Signature: _____ Date: _____

DENTAL HISTORY

Chief oral complaint: _____
 Date of last exam: _____ Any previous major dental treatment Yes No
 When: _____

Do you have or do you use any of the following? – indicate with a (✓)

- | | | |
|---|---|--|
| <input type="checkbox"/> Teeth sensitive to cold, heat, or pressure | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Cigarettes, pipe or cigar smoking |
| <input type="checkbox"/> Bleeding gums. How long _____ | <input type="checkbox"/> Unpleasant taste | <input type="checkbox"/> Texture of toothbrush _____ |
| <input type="checkbox"/> Food impaction | <input type="checkbox"/> Unfavorable dental experience | <input type="checkbox"/> Frequency of brushing _____ |
| <input type="checkbox"/> Burning of tongue | <input type="checkbox"/> Complications from extractions | <input type="checkbox"/> Dental floss |
| <input type="checkbox"/> Swelling or lumps in mouth | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Inter dental stimulators |
| <input type="checkbox"/> Frequent blisters on lips or mouth | <input type="checkbox"/> Orthodontic treatment | <input type="checkbox"/> Water jet device |
| <input type="checkbox"/> Pain around ear | <input type="checkbox"/> Mouth breathing | <input type="checkbox"/> Disclosing tablet or solution |
| <input type="checkbox"/> Unusual sounds in ear while eating | <input type="checkbox"/> Oral habits, i.e., fingernail biting, cheek biting, etc. | <input type="checkbox"/> Fluoride supplements |

GENERAL DENTISTRY INFORMED CONSENT

NAME: _____

1. TREATMENT TO BE DONE:

2. DRUGS AND MEDICATION:

I understand that antibiotics, analgesics, and other medications can cause allergic reactions resulting in redness, swelling of tissues, pain, itching, and/or anaphylactic shock (severe allergic reaction). (Initials _____)

3. CHANGES IN TREATMENT PLAN:

I understand that it may be necessary to change or add procedures due to conditions found during treatment. I give my permission to the Dentist to make any/all changes and additions as necessary with my consent. (Initials _____)

4. REMOVAL OF TEETH:

Alternatives to removal have been explained to me (root canal therapy, crowns, periodontal surgery, etc.), and I authorize the Dentist to remove the recommended teeth. I understand removing does not always remove all the infection, and it may be necessary to have further treatment, I understand there are risks involve 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, months, or in some rare cases, permanently) or fractured jaw. I understand that I may need further treatment by a specialist of even hospitalization if complications arise during or following a treatment, the cost of which my responsibility. (Initials _____)

5. CROWNS, BRIDGES, AND VENEERS:

I understand sometimes it is not possible to match the color of natural teeth exactly with artificial material. I further understand I may be wearing temporary crowns, which may come off. I must be careful to ensure that they are kept in place until the permanent crown(s) are delivered. I realize the final opportunity to make changes to my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation. I understand if I so not return for my schedule appointment for delivery of my crown, bridge or cap it may not fit properly, and I will be responsible for any lab fees incurred if a remake becomes necessary. (Initials _____)

6. DENTURES-COMplete OR PARTIAL:

I realize 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 most dentures require relining approximately tree to six months after initial placement and yearly thereafter. The cost for these relines is not included in the initial denture fee. (Initials _____)

7. ENDODONTIC TREATMENT (ROOT CANAL):

As with all dental treatment there is no guarantee that root canal therapy will save my tooth, and complications can occur (such as pain or infection) from the treatment. I understand that occasionally additional surgical procedures and/or referral to a specialist may be necessary following root canal treatment (Apicoectomy). (Initials_____)

8. PERIODONTAL LOSS (TUSSIE & BONE):

I understand that I have a serious condition and my Dentist my advise me to have a consultation with the Periodontist. I understand that not undertaking periodontal treatment will have an adverse effect on my periodontal condition and could lead to the loss of some or all my teeth. (Initials_____)

9. SEALANTS:

I realize that there is no guarantee with the application of sealants on my child. Depending on the child’s hygiene, sealants may dissolve or break away from the tooth causing possible decay. (Initials_____)

10. SPACE MAINTAINERS:

I understand that a space maintainer is a fixed appliance. I further understand that I am fully responsible to have the appliance checked every 6 months. (Initials_____)

11. FILLING/BONDING:

I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling that originally diagnosed may be required do to additional decay. I understand that significant sensitivity is common aftereffect of a new placed filling. (Initials_____)

I understand that dentistry is not an exact science and that therefore practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding dental treatment, which I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me.

Signature: _____ Date: _____

Doctor: _____ Witness: _____

**South Coast Dental Center
3500 S. Bristol St. suite 101
Santa Ana, Ca 92704
714-556-1717**

Patient Financial Agreement

- 1. Payment:** Our office requires full payment or Insurance co-payment at the time of services unless previous financial arrangements are made.
- 2. Insurance:** As a courtesy to our patients, we will bill your insurance on your behalf, but ultimately it is the patient's responsibility to pay for the amount of the services rendered by our office. If the account is 60 days past due, a finance charge of 1.5% per month or 18% APR will be charged until account is paid in full.
- 3. We accept Credit Cards:** Visa, Master Card, American Express and Discover for payment.
- 4. We offer Care Credit:** A payment plan with **0% interest for 12 months** on approved credit.
- 5. We accept Personal Checks,** but in the event that the check is returned for insufficient funds there is a \$25 returned check fee.
- 6. Appointments:** A minimum charge of \$50 will be made for a failed or a cancelled appointment without a prior notification of 24 hours. This fee covers only a portion of the overhead such as salaries, rent etc. which still has to be paid. Once an appointment is made, **please remember this time has been reserved for you, kindly give us advance notice.**

We at South Coast Dental Center appreciate your business and please let us know if you need any help or have additional questions to be answered. Thank you in advance for your cooperation.

Signature: _____ Date: _____
(Patient or Guardian if patient is a minor)

Are you happy with your smile Survey?

Hold a mirror 12 to 14 inches from your face. Smile to show your teeth take the time to observe your teeth carefully, and then answer the following questions. If you are not happy with the appearance of your teeth, ask us how we can improve your smile.

1. Do you like the appearance of your teeth; your smile. Yes No
If not. Explain _____

2. Are your teeth all in alignment (straight)? Yes No
If not. Explain _____

3. Do you have shades that you don't like? Yes No
If not. Explain _____

4. Do you like the color of your teeth? Yes No
If not. Explain _____

5. Do you like the shape of your teeth? Yes No
If not. Explain _____

6. Are your teeth ...
Chipped? _____ Protruding? _____ Hidden? _____

7. Are your teeth wearing on the biting surfaces? Yes No
If yes. Explain _____

8. Are there old filling or dental work you don't like looking at? Yes No
If yes, Explain _____

9. What would you like to change the most in the appearance of your teeth?

10. How would you like your teeth to look?

Adjunctive Oral Cancer Screening Acceptance Form

Complete each time the examination is performed and place in the patient's file

Our practice continually strives to provide important enhancements in oral health care for our patients. We are concerned about oral cancer and look for it in all at risk patients.

One person dies every hour from oral cancer in the United States.

Late detection of oral cancer is the primary reason that mortality rates are so dismal. As with most other cancers, age is the primary risk factor for oral cancer. Though tobacco use is a major predisposing risk factor, **25% of oral cancer victims have no lifestyle risk factors.**

Oral Cancer Risk profile

Increase risk

- Patients age 40 and older (95% of all cases)
- 18-39 years of age combined with any of the following:
 - Tobacco use
 - Chronic alcohol consumption
 - Oral HPV infection

Highest risk

- Patients age 65 and older with lifestyle risk factors
- Patients with history of oral cancer

25% of oral cancers occurs in people who don't smoke and have no other risk factors.

We find that using ViziLite Plus along with a visual oral cancer examination improves our ability to identify suspicious areas that may have been missed during the conventional examination. Early detection of precancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. ViziLite Plus is a painless exam that gives us a better chance to find any oral abnormalities you may have at an early stage.

Dental insurance might not cover the ViziLite Plus exam. However, this office is happy to verify your coverage for you and will also provide you with a medical insurance form for you to use to file this procedure with your medical insurance. The fee for this enhanced examination is \$_____

Yes. I authorize the clinician to perform the ViziLite Plus exam along with the standard oral cancer examination. I accept financial responsibility for this enhanced examination.

Print Name: _____

Signature: _____ Date: _____

No: I would prefer not to have the ViziLite Plus exam at this time.

Print Name: _____

Signature: _____ Date: _____