



Welcome

Name: _____ Nickname: _____ Male / Female Birthday: _____ Age: _____
Address: _____ Zip: _____ Home Phone () _____
Marital Status: _____ Driver's Lic#: _____ State: _____ Exp: _____ Cell Phone () _____
Employer: _____ Occupation: _____ Work Phone () _____
Social Security#: _____ E-mail Address: _____
Emergency Contact: _____ Phone () _____
Nearest Relative not living with you: _____ Phone () _____
Who can we thank for referring you? _____

Parent/Spouse Information

Name: _____ Male / Female Birthday: _____ Age: _____
Address: _____ Zip: _____ Phone () _____
Employer: _____ Occupation: _____ Social Security#: _____

Insurance Information

Primary Insurance Company: _____ ID#: _____ Group/Policy#: _____
Employer / Self: _____ Address: _____ Zip: _____ Phone () _____
Subscriber's Name: _____ Birthday: _____ Social Security#: _____
Secondary Insurance Company: _____ ID#: _____ Group/Policy#: _____
Employer / Self: _____ Address: _____ Zip: _____ Phone () _____
Subscriber's Name: _____ Birthday: _____ Social Security#: _____

Other Information

May we discuss/disclose personal/health information with any family member?

Name: _____ Y / N Name: _____ Y / N
Name: _____ Y / N Name: _____ Y / N
Name: _____ Y / N Name: _____ Y / N

I acknowledge responsibility and accuracy of the information on this form:

Signature: _____ Date: _____

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication

Are you under a physician's care now? Yes No If yes _____

Have you ever been hospitalized or had a major operation? Yes No If yes _____

Have you ever had a serious head or neck injury? Yes No If yes _____

Are you taking any medications, pills, or drugs? Yes No If yes _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes _____

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics

Other? If yes _____

Do you use controlled substances? Yes No If yes _____

Do you have, or have you had, any of the following?

| | | | |
|--|--|--|---|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No | Hemophilia <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No | Diabetes <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No |
| Anemia <input type="radio"/> Yes <input type="radio"/> No | Easily Winded <input type="radio"/> Yes <input type="radio"/> No | Herpes <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No |
| Angina <input type="radio"/> Yes <input type="radio"/> No | Emphysema <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Rheumatism <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No | Shingles <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No |
| Asthma <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No | Leukemia <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problems <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No | Liver Disease <input type="radio"/> Yes <input type="radio"/> No | Stroke <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No |
| Cancer <input type="radio"/> Yes <input type="radio"/> No | Glaucoma <input type="radio"/> Yes <input type="radio"/> No | Lung Disease <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No | Hay Fever <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No | Ulcers <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No |
| | | | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No |

Have you ever had any serious illness not listed Yes No If yes _____

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: _____

Dental History

Previous Dentist _____

Last x-rays taken _____

Last cleaning _____

Major dental problem and/or reason for coming _____

Do you or have you ever had:

YES NO Bad Breath

YES NO Bleeding Gums

YES NO Burning Mouth

YES NO Clenching

YES NO Dry Mouth

YES NO Grinding

YES NO Braces

YES NO Gum Treatment or Surgery

YES NO Injury to head or neck

YES NO Loose Teeth

YES NO Jaw Pain or Tiredness

YES NO Mouthguard

Are you able to sit for a three hour dental appointment? _____

Are you active in sports? _____

Is there anything about the appearance of your smile you would like to change? _____

Did you ever avoid a dental appointment because you were frightened? _____

Have you ever been dissatisfied with dental treatment? Please describe. _____

PLEASE DO NOT WRITE BELOW THIS LINE

ASA Class: _____ Dr. Signature: _____ Date: _____

Doctor's notes: _____

Patient Acknowledgment of receipt of Dental Materials Fact Sheet

I, _____, acknowledge that I have received and reviewed from Pacific Coast Dentistry, a copy of the Dental Materials Fact Sheet dated October 2001.

Patient Signature

Date

The following document is the Dental Board California's Dental Materials Fact Sheet. The Department of Consumer Affairs has no position with respect to the language of this Dental Materials Fact Sheet; and its linkage to the DCA site does not constitute an endorsement of the content of this document.

The Dental Board of California Dental Materials Fact Sheet

Adopted by the board on October 17, 2001

As required by Chapter 801, Statutes of 1992, the Dental Board of California has prepared this fact sheet to summarize information on the most frequently used restorative dental materials. Information on this fact sheet is intended to encourage discussion between the patient and dentist regarding the selection of dental materials best suited for the patient's dental needs. It is not intended to be a complete guide to dental materials science.

The most frequently used materials in restorative dentistry are amalgam, composite resin, glass ionomer cement, resin-ionomer cement, porcelain (ceramic), porcelain (fused-to-metal), gold alloys (noble) and nickel or cobalt-chrome (base-metal) alloys. Each material has its own advantages and disadvantages, benefits and risks. These and other relevant factors are compared in the attached matrix titled "Comparisons of Restorative Dental Materials." "A Glossary of Terms," is also attached to assist the reader in understanding the term used.

The statements made are supported by relevant, credible dental research published mainly between 1993-2001. In some cases, where contemporary research is sparse, we have indicated our best perceptions based upon information that predates 1993.

The reader should be aware that the outcome of dental treatment or durability of a restoration is not solely a function of material from which the restoration was made.

The durability of any restoration is influenced by the dentist's technique when placing the restoration, the ancillary materials used in the procedure, and the patient's cooperation during the procedure. Following restoration of the teeth, the longevity of the restoration will be strongly influenced by the patient's compliance with dental hygiene and home care, their diet, and chewing habits.

Acknowledgement of privacy policies and consent for use and disclosure of personal health information

This form authorizes us to use and disclose your protected health (PHI) for the purposed of healthcare operation, treatment and payment activities.

Before signing, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your PHI.

I, _____, have read your Notice of Privacy Policies and I consent your use of my PHI for the purposed of healthcare operations, treatment and payment activities.

If this consent is signed by personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Office Financial Policy

We require payment at the time of service. We expect you to cover the cost of your dental treatment as service is rendered. For your convenience we accept Visa, MasterCard, Discover, American Express, Cash, or Personal check as payment. Outside financing is available on approved credit.

- We send out monthly statements directly from our office. Full payment is due unless the balance is expected to be paid by insurance.
- Those patients with insurance are expected to pay their estimated amount at the time of their appointment. You are responsible for payment of your account whether or not your insurance pays their estimated portion.
- We will assist you in planning your treatment around your financial considerations, and will always work to help you understand your insurance benefits. We require updated benefit information at all times in order to accurately estimate payment due.
- Those with dental insurance authorize payment of the dental benefits otherwise payable to you directly to Pacific Coast Dentistry and the release of any information relating to insurance claims.

Appointment Reservation Agreement

Here at Pacific Coast Dentistry we view you as an internal part of your oral health care team and feel that to best maintain your health, we ask that you follow these guidelines. Because time is valuable, we ask you respect your reserved appointment time with us.

We agree to be respectful of your time when you are in our office and in order for us to keep our costs low it is important that our patients agree to committing to their reserved times.

As a courtesy we send reminders three weeks prior to your reservation. We ask that your contact us within a week of receiving this reminder should you need to make any changes.

Within four days of your reserved appointment we send a final reminder and we request you confirm with us that you are aware and we will be seeing you on time.

Your oral health is our priority, missed and/or delayed treatment may increase your risk to more extensive care in the long run.

If patients fail to respect this agreement, we reserve the right to require a non-refundable deposit to hold future reservations.

Thank you for being such a willing part of your oral health care. We look forward to providing you and your family quality and compassionate dental care.