New Patient Dental Intake Form

Patient Information

Name: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Email: _____

Sex: ❑ M ❑ F Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Partnership ❑ Widowed

Employer or School: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Spouse, partner or parent name: _____

Person to contact in case of an emergency: _____ Phone: _____

How did you learn about our practice or whom may we thank for referring you? _____

Who is responsible for your account and payment? (if different from previous listing): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____ Birthdate: _____

Dental Insurance

Insurance company: _____ Phone # _____

Subscriber's Social Security # _____ Group # _____ ID # _____

Address: _____ City: _____ State: _____ Zip: _____

How much is your deductible? _____ How much have you used? _____ What is your annual maximum benefit? _____

Whose name is this insurance under? _____

Employer offering this insurance? _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Secondary Dental Insurance

Insurance company: _____ Phone # _____

Subscriber's Social Security # _____ Group # _____ ID # _____

Address: _____ City: _____ State: _____ Zip: _____

How much is your deductible? _____ How much have you used? _____ What is your annual maximum benefit? _____

Whose name is this insurance under? _____

Employer offering this insurance? _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Dental History

Reason for today's visit: _____

Date of last dental care visit: _____ Date of last dental x-rays: _____

Former dentist's name: _____ Phone: _____

Check if you have any problem with the following:

❑ Bad breath
❑ Bleeding gums
❑ Clicking or popping jaw
❑ Food collection between certain teeth
❑ Grinding teeth
❑ Loose teeth or broken fillings
❑ Periodontal treatment
❑ Sensitivity to any of the following: cold, hot, sweets
❑ Sensitivity when biting
❑ Sores or growth in your mouth

How often do you floss? _____ How often do you brush? _____

Medical History

Your physician: _____ Date of last visit: _____

Have you ever taken any of the groups of drugs collectively referred to as "fen-phen"? ❑ Yes ❑ No

Have you had any serious illnesses or operations? ❑ Yes ❑ No

If yes, describe: _____

Have you ever had a blood transfusion? ❑ Yes ❑ No

If yes, give approximate dates: _____

Women: are you pregnant? ❑ Yes ❑ No

Are you nursing? ❑ Yes ❑ No

Are you taking birth control? ❑ Yes ❑ No

Check if you have or have had any of the following:

- ❑ Anemia
- ❑ Arthritis, rheumatism
- ❑ Artificial heart valves
- ❑ Artificial joints, pins, etc.
- ❑ Asthma
- ❑ Bleeding abnormally
- ❑ Blood disease
- ❑ Cancer
- ❑ Chemical dependency
- ❑ Chemotherapy
- ❑ Circulatory problems
- ❑ Congenital heart lesions
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart murmur
- ❑ Heart problems
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ High blood pressure
- ❑ HIV AIDS
- ❑ Jaw pain
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Mitral valve prolapse
- ❑ Pacemaker
- ❑ Radiation treatment
- ❑ Respiratory disease
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Sexually transmitted disease
- ❑ Stroke
- ❑ Swelling of feet or ankles
- ❑ Thyroid problems
- ❑ Tobacco use
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer

List medications you are currently taking and the correlating diagnosis:

Medication	Diagnosis

Please list any allergies you may have:

Allergy	Allergy

To the best of my knowledge, the above information is complete and correct.
I understand that it is my responsibility to inform my doctor if I or my minor child has a change in health.

_____ _____

Patient or Guardian Signature *Date*

PATIENT CONSENT TO TREATMENT

1. DRUGS, MEDICATION, AND ANESTHESIA Initials_____

-I understand that antibiotics, analgesics, and other medications may cause adverse reactions, some of which are, but are not limited to, redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest.

-I understand that medications, drugs, and anesthetics may cause drowsiness and lack of coordination, which can be increased by the use of alcohol or other drugs. I have been advised not to consume alcohol, not to operate any vehicles or hazardous device while taking medications and/or drugs, or until fully recovered from their effects (this include a period of at least twenty four hours after my release from surgery).

-I understand that occasionally, upon injection of a local anesthetic, I may have prolonged persistent anesthesia, numbness, and/or irritation to the area of injection.

-I understand that if I select to utilize Nitrous Oxide, "Atarax", Chloral hydrate, "Zanax", or any sedative, possible risk include, but are not limited to, loss of consciousness, obstruction of airway, anaphylactic shock, and cardiac arrest. I understand that someone needs to drive me home from dental office after I have received sedation, I also understand that someone needs to watch me closely for a period of 8 to 10 hours, following my dental appointment, to observe possible deleterious side effects, such as obstruction of airway.

2. HYGIENE Initials_____

-I understand that the long term success of treatment and status of my oral condition depends on my efforts at proper oral hygiene(i.e. brushing and flossing) and maintaining regular recall visits.

3. PERIODONTICS (TISSUE AND BONE LOSS)

-I understand that I have serious condition, causing gum and bone inflammation and/or loss, and that it can lead to loss of my teeth and other complications. The various treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I also understand that although these treatment have a high degree of success, they cannot be guaranteed. Occasionally treated teeth may require extraction.

4. REMOVAL OF TEETH Initials_____

-I understand that the purpose of the procedure/surgery is to treat and possible correct my diseased oral tissues. The doctor has advised me that if this condition persist without treatment or surgery, my present oral condition will probably worsen in time.

-POTENTIAL RISKS INCLUDE, BUT ARE NOT LIMITED TO, THE FOLLOWING:

-post-operative discomfort, swelling, delayed healing(dry socket) and/or infection (requiring prescription or additional treatment, i.e. surgery)

-injury to adjacent teeth, caps, or fillings (requiring the recementation of crowns, replacement of fillings,, fabrication of crowns or extraction) or injury to other tissues not within described surgical area.

-Limitation of opening; stiffness of facial and/or neck muscles; change in bite; temporomandibular joint(jaw joint) difficulty (possibility requiring physical therapy or surgery)

-residural root fragments of bone spicules left when complete removal would require extensive surgery or needless complications.

-possible bone fracture which may require wiring or surgical treatment.

-opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery

-injury to the nerve underlying the teeth resulting in itching, numbness, or burning of the lip, chin, gums, cheek, teeth, and/or tongue on the operated side: this may persist for several weeks, months, or, in remote instances, permanently.

I give my consent for the doctor to perform the treatment/procedure/surgery previously explained to me, or other procedures deemed necessary or advised as necessary to complete the planned operation. If any unforeseen condition should arise in the course of the operation, calling for the doctor's judgment or for procedures in addition to or different from those now contemplated , I request and authorize the doctor to do whatever he deem advisable, including referral to another dentist or specialist. I also understand that the cost of this referral would be my responsibility.

5. FILLINGS Initials_____

-I have been advised of the need for filings, either silver or composite(plastic), to replace tooth structure lost to decay. I understand that with time fillings will need to be replaced due to wearing of material. In cases where very little tooth structure remains, or existing tooth fractures off, I may need to receive more extensive treatment(such as root canal therapy, post and build-up, and crowns), which would necessitate a separate charge.

6. ENDODONTIC THERAPY (ROOT CANAL THERAPY) Initials_____

-the purpose and method of root canal therapy have been explained to me, as well as reasonable alternative treatment, and the consequences of non-treatment. I understand that following root canal therapy my tooth will be brittle and must be protected against fracture by replacement of a crown(cap) over the tooth.

-I understand that treatment risk can include, but not limited to the following:

-post treatment discomfort lasting a few hours to several days for which medication will be prescribed if deemed necessary by the doctor

-post treatment swelling of the gum area in the vicinity of the treated tooth or facial swelling, either of which may persist for several days or linger.

-infection

-restricted jaw opening

-separation of root canal instruments during treatment, which may in the judgement of the doctor, be left in the treated root canal or bone as part of the filling material, or it may require surgery for removal.

-perforation of the root canal with instrument, which may require additional surgical treatment or result in premature tooth loss or extraction.

-risk of temporary or permanent numbness in treatment area

If and "open and medicate" or pulpotomy procedure is performed, I understand that this is not permanent treatment, and I need to pay for, and finish root canal therapy. If root canal treatment is not finalized I expose myself to infection and/or tooth loss. If failure of root canal therapy occurs, the treatment may have to be redone, root-end surgery may be required, or the tooth may have to be extracted

7. CROWN AND BRIDGE Initials_____

- I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I understand that at times, during the preparation of a tooth for a crown, pulp exposure may occur, necessitating possible root canal therapy.

-I understand that like natural teeth, crowns and bridges need to be kept clean, with proper oral hygiene and periodic cleanings, otherwise decay may develop underneath and/or around the margins of the restoration,leading to further dental treatment.

8. DENTURES-COMPLETE OR PARTIAL Initials_____

-the problems of wearing dentures have been explained to me including looseness, soreness, and possible breakage, and relining due to tissue change. Follow-up appointments are an an integral part of maintenance and success of a prosthetic appliance. Persistent sore spots should be immediately examined by the doctor.

-I further understand that surgical intervention(i.e. tori removal, bone recountouring, or implants) may be neededfor dentures to be properly fitted. I also understand that due to bone loss or other complicating factors, I may never ba able to wear dentures to my satisfaction.

I UNDERSTAND THAT NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN THAT THE PROPOSED TREATMENT WILL BE CURATIVE AND/OR SUCCESSFUL TO MY COMPLETE SATISFACTION. I AGREE TO COOPERATE COMPLETELY WITH THE RECOMMENDATIONS OF THE DOCTOR WHILE I AM UNDER HER CARE, REALIZING THAT ANY LACK OF SAME COULD RESULT IN LESS THAT OPTIUM RESULTS.

I CERTIFY THAT I HAVE THE OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE, INCLUDING THE OPPOSING SIDE OF THE DOCUMENT, AND CONSENT TO OPERATION AND EXPLANATION REFERRED TO OR MADE. I HAVE BEEN ENCOURAGED TO ASK QUESTIONS, AND HAVE THEM ANSWERED TO MY SATISFACTION

Signature of patient/legal representative:_____ date:_____

Doctor:_____ witness:_____ date:_____

Notice of Privacy Policies

Last Name: _____ First Name: _____ Birthdate: _____

Date: _____

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

Designed Smiles

1770 E. Lambert Rd. #110

Brea, CA 92821

No call / No show

In effort to provide effective and efficient treatment to all our patients, it is the policy of this office that all appointment cancellations are made at least 24 hours prior to your scheduled appointment time.

If any appointment is not cancelled or patient fails to show up for appointment, Designed Smiles reserves the right to charge patient a $45 fee per occurrence. As this fee is not billed to any insurance company, patients accept full responsibility to pay this fee.

If you have any questions about this form, please talk to us before signing.

Patient's Name: _____

Patient/Guardian Signature: _____

Date: _____