Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: ____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

(Cell)_____

Email: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address:

Name:_____

Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Whom may we thank for the referral to our office?

Name: _____ Relationship: _____

Emergency Contact

Name: _____ Relationship: _____

Phone Number: _____

Consent for Communications

I grant my permission to Orange Coast Dental to upload and store confidential patient information — including account information, appointment information and clinical information — to the secured computers for Orange Coast Dental. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand Orange Coast Dental and myself are responsible for maintaining the strict confidentiality of any information; and that Orange Coast Dental is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I also understand State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand Orange Coast Dental will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my patient information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that Orange Coast Dental has the right to monitor, retrieve, store, upload and use my patient information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand Orange Coast Dental will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the server on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBLITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMAION TRANSMITTED, MOITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR SERVICES.

I understand Orange Coast Dental WILL NOT SHARE ANY INFORMATION WITH ANY FAMILY OR OTHER PARTY WITHIN YOUR FAMILY/FRIENDS WITHOUT A WRITTEN AUTHORIZATION BY THE PATIENT. IF I WISH TO HAVE STAFF SPEAK TO A THIRD PARTY (THAT IS NOT IN RELATION TO INSURANCE OR REFERRALS) IN REGARDS TO MY INFORMATION I WILL SUBMIT A WRITTEN CONSENT WITH THE OTHER PARTIES INFORMATION FOR APPROVAL OF COMMUNICATION.

☐ I CONSENT TO USE MY INFORMATION IN REFRENCE TO ANY REFERALS OR INSURANCE PURPOSES WITH OTHER DENTAL OFFICES AND INSURANCE COMPANIES IN REFRENCE TO MY TREATMENT AT ORANGE COAST DENTAL _____(INITALS)

I have read the information above regarding the secured uploading of patient information for Orange Coast Dental, and grant Orange Coast Dental permission to securely upload my patient information to the server.

_____ Signature of patient, parent or guardian

Relationship to Patient:_____

Date: _____

Consent for Services and Financial Agreement

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

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

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he/she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that I will be informed of the estimated treatment plan and estimated associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. To the extent permitted by law, I consent for the office to use my protected health information to carry out payment activities in connection to my claims or referrals for your specialty care.

As a courtesy to the patients the office attempts to verify dental insurance coverage upon becoming a patient of record, but I understand that it is my responsibility to know my plan coverage, limits, and exclusions. Furthermore, I understand that I am responsible for being aware of non-covered benefits such as missing tooth, crown, bridge, denture restorations, bruxism, downgrade limitations for fillings and porcelain crowns, as well as frequency limits.

All estimates are subject to approval by my dental coverage plan therefore the amount due is subject to change after final explanation of benefits have been paid by my insurance.

I understand that the fee estimate listed for dental care can only be extended for a period of one month from the date of patient examination.

In addition if my plan changes it is my responsibility to notify the office before treatment is rendered.

In consideration for the professional services rendered to me I agree to pay therefore the value of said services to the office at the time said services are rendered or within extended time agreed upon in writing with the office. I further agree that any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee to telephone me at home, cellphone, work, text, or email to discuss matters related to this form, my treatment, my insurance, my account, and my bill. I may withdraw my consent in writing at any time.

A service charge of 1.5% (18% per year) on the unpaid balance will be charged on all accounts exceeding 30 days unless previously written financial arrangements are satisfied.

I have read the above conditions of treatment, policy, and payment and agree to their content.

_____ **Signature of responsible party**

_____ **Date**

_____ **Relationship to Patient**

DENTAL TREATMENT CONSENT FORM

Please read and initial the items checked below
and read and sign the section at the bottom of the 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 of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reactions). (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 th teeth that were not discovered during examinations, 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 other necessary for reasons in paragraph #3. I understand that removing teeth does not always remove infections. 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 (Paresthesia) 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 hospitalized if complications arise during or following treatment, the cost of which is m 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 may be wearing temporary crowns, which may come off easily and that I must be careful to insure 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. (Initial_____)

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 loosness, soreness, and possible breakage. I realize the final opportunity to make changes i 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 of this procedure in not included in the initial denture fee. (Initial_____)

7. ENDODONTIC TREATMENT (ROOT CANAL)

I realize that that there is no guarantee that root canal treatment will save my tooth and that complications can occur from the treatment, and 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). (Initial_____)

8. PERIODONTAL LOSS (TISSUE AND BONE)

I understand that I have a serious condition, causing gum and bone infection or loss and that it can lead to the loss of my teeth Alternative treatment plans have been explained to me, including my gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on periodontal condition. (Initial_____)

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_____

Orange Coast Dental 1717 OLD TUSTIN AVE. SANTA ANA, CA 92705 (714)835-9188 FAX: (714)835-2647

Orange Coast Dental

1717 Old Tustin Ave
Santa Ana Ca 92705
714-835-9188

MEDICAL HISTORY

Please Circle Appropriate Response:

NO YES **Are you in good general health?**

NO YES Are you now taking any drugs or medications?

Which ones?_____

_____

_____

NO YES Are you allergic to penicillin?

NO YES Do you have any other allergies? Which ones?

_____

_____

Family Doctor:_____

Phone:_____

_____

NO YES Would you object to our office contacting your family doctor in regard to any medical problem that may arise?

_____

NO YES Have you ever received local anesthesia (Novocaine or Xylocaine) by a dentist or doctor?

NO YES Have you ever received general anesthesia?

NO YES Have you ever had any adverse reaction to either local or general anesthesia?
Please describe_____

NO YES Do you take blood thinners?
Which ones? _____

NO YES Do you take vitamins regularly?
Which ones?_____

NO YES Do you take vitamins containing Vitamin E?

NO YES Do you take aspirin products or anti-inflammatory medicines or headache medicines?
Which ones?_____

NO YES Do you exercise regularly?

PLEASE LIST ALL PREVIOUS SURGERIES AND DATES:

_____

_____

DO ANY FAMILY MEMBERS HAVE: (Circle if yes)

Heart trouble
Excessive scarring
Diabetes
Adverse reactions to anesthesia
Tuberculosis
Excessive bleeding tendency
Psychiatric or "nerve" problems

HAVE YOU HAD:

NO YES Blood pressure or related problems
NO YES Liver, gallbladder, problems
NO YES Have you ever had joint replacement surgery?
NO YES Heart problems
NO YES Kidney disease
NO YES Diabetes
NO YES Stomach problems, indigestion or ulcers
NO YES Bleeding tendency or excessive bruising
NO YES Any part of your body paralyzed or numb
NO YES Psychiatric consultation
NO YES Epilepsy-convulsions or seizures
NO YES Broken bones of the face, neck, jaw or back
NO YES Back trouble
NO YES Abnormal chest x-rays
NO YES Abnormal Electrocardiogram (ECG)
NO YES Asthma or other respiratory problems
NO YES Any medical treatment for nervous condition
NO YES Excessive scarring
NO YES Tuberculosis
NO YES Thyroid problems
NO YES Allergy to Latex
NO YES A gain or loss of more than 15 pounds in your body weight with in 6-12 months
NO YES Abdominal or inguinal hemia
NO YES History of blood clots in legs or lungs
NO YES Have you ever taken/do you take bisphosphonates ie Fosamax?
NO YES Glaucoma, cataracts
NO YES Herpes or Cold Sores
NO YES Any other illnesses. If so please list:

Other:_____

DO YOU:

NO YES Wear contact lenses?
NO YES Have dentures, false teeth, caps or bridges
NO YES Smoke? How much? _____
NO YES Drink alcohol? How much? _____
NO YES Think you are pregnant? Date of last menstrual period_____
NO YES Have any contagious or infectious condition
NO YES Have you been exposed directly or indirectly to any one with HIV (AIDS)

The above information is strictly confidential

Patient Signature Date

Witness Signature Date