For your convenience you may use your keyboard and mouse to complete this form.. Our goal is to help you achieve and maintain excellent dental health. The better we communicate, the better we can care for your needs. If you have any questions, we'll be glad to help! Please print the form and fax, mail or bring it with you to your next appointment. Our fax number is: 951-929-7090 and our mailing address is: Hemet West Dental Office, 3232 West Florida Avenue, Hemet, CA 92545-3622

Our Commitment to You

We would like to take this opportunity to welcome you to our dental practice. We are pleased that you have chosen us as your dental care team and want you to know that we are committed to providing you with the highest quality dental care in the most gentle, efficient and enthusiastic manner possible! We appreciate your understanding in our efforts to maintain respectful guidelines for our practice to keep the caliber of care and service extraordinary.

Treatment
Our goal is to build a long-term relationship with you in a relaxed and friendly environment. We are committed to helping you preserve your natural teeth for life and to maintain your oral health at an optimum level. We want to assure you we will be with you every step of the way and welcome any questions you may have.

By initialing this section and signing below, you indicate that you understand and agree to these treatment guidelines. ***Initial*** ____________

Financial Arrangements
Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important, life-enhancing care. We are available to answer your questions and assist you in any way we can. We happily accept cash, checks, credit cards (VISA, MC, and Discover) and long term outside financing through Care Credit (o.a.c.). All financial arrangements must be made in advance with a member of our team. Please be prepared to pay any estimated patient portion co-pays at the time treatment is provided.

By initialing this section and signing below, you indicate that you understand and agree to these financial guidelines. ***Initial*** ____________

Insurance
We are pleased that you have dental insurance to help you with partial assistance in affording your dental care. As a courtesy, we are happy to assist you in filing the necessary forms to help you receive the full benefits of your dental insurance coverage at no additional cost. Dental insurance is different than most medical insurance plans and it is important to be aware of the following:
" Insurance is an agreement between you and your insurance company. The insurance relationship constitutes an agreement between the carrier, the employer, and the patient. Our dental office is not a party to that contract. As such, we can make no guarantee of estimated coverage or payment. Please know that we will do everything possible to see that you receive the full benefits of your policy.

By initialing this section and signing below, you indicate that you understand and agree to these insurance guidelines. ***Initial*** ____________

Appointments
We pre-plan and prepare for your visit and hope you have done the same. Your appointment time has been reserved especially for you and we strongly encourage all patients to keep their appointments. When time is lost due to last-minute changes, other patients in need of treatment cannot be seen and your treatment is delayed, often resulting in negative consequences.

Should any scheduling changes be required, we require at least 24 hours advance notice to avoid a $75.00 cancellation fee.

Courtesy Reminder Calls
We consider all appointments confirmed when they are made. As a courtesy, we make every effort to remind patients by telephone or email prior to their appointment but please do not depend on this courtesy. We have found that with the recent popular use of answering machines, cell phones, pagers, and voice mails, some of our patients may not receive these reminder calls.

If we are unable to speak with you directly, your appointment card will serve as confirmation and implies your obligation to be present at that prearranged date and time.

By initialing this section and signing below, you indicate that you understand and agree to these appointment guidelines. ***Initial*** ____________

We appreciate your understanding in our efforts to provide you with an extraordinary dental experience.

Patient Signature:____

Guardian Signature:____

Date: _________________________

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welcome

PATIENT NUMBER

Date ______

Patient's Name ______ (Last) ______ (First) ______ (Initial) Date of Birth ______ ❑ Male ❑ Female

If Child: Parent's Name ______

How do you wish to be addressed ______

Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Minor ❑

Residence - Street ______

City ______ State ______ Zip ______

Business Address ______

Telephone: Res. ______ Bus ______

Fax ______ Cell Phone # ______

eMail ______

Patient/Parent Employed By ______

Present Position ______

How Long Held ______

Spouse/Parent Name ______

Spouse Employed By ______

Present Position ______

How Long Held ______

Who is Responsible for this account ______

Drivers License No. ______

Method of Payment Insurance ❑ Cash ❑ Credit Card ❑

Purpose of Call ______

Other Family Members in this Practice ______

Whom may we thank for this referral ______

Patient/parent Social Security No. ______

Spouse/Parent Social Security No. ______

Someone to notify in case of emergency not living with you

______

Dental Insurance 1st Coverage

Employee Name ______ Date of Birth ______

Employer Name ______ Yrs. ______

Name of Insurance Go. ______

Address ______

City ______ State ______ Zip ______

Telephone ______

Program or policy # ______

Social Security No ______

Union Local or Group ______

Dental Insurance 2nd Coverage

Employee Name ______ Date of Birth ______

Employer Name ______ Yrs. ______

Name of Insurance Go. ______

Address ______

City ______ State ______ Zip ______

Telephone ______

Program or policy # ______

Social Security No. ______

Union Local or Group ______

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any Information concerning my (or my child's) health care, advice and treatment to another dentist

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carder or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in pad by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENTS OR GUARDIAN'S SIGNATURE

______

DATE ______

Form No. T11OR

REGISTRATION

PATIENT NUMBER

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Patient's Name ______ Last ______ First ______ Initial ______ Date of Birth

1. Purpose of initial visit ______
2. Are you aware of a problem? ______
3. How long since your last dental visit? ______
4. What was done at that time? ______
5. Previous dentist's name ______
   Address: ______ Tel. ______
6. When was the last time your teeth were cleaned? ______

CLICK THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW ON THE LINE AFTER THE QUESTION.

7. Have you made regular visits? ❒ YES ❒ NO
   How often: ______
8. Were dental x-rays taken? ❒ YES ❒ NO
9. Have you lost any teeth or have any teeth been removed? ❒ YES ❒ NO
   Why? ______
10. Have they been replaced? ❒ YES ❒ NO
11. How have they been replaced?
    a. Fixed bridge ______ Age ______
    b. Removable bridge ______ Age ______
    c. Denture ______ Age ______
12. Are you unhappy with the replacement? ❒ YES ❒ NO
    If yes, explain ______
13. Would you like to know about permanent replacements? ❒ YES ❒ NO
14. Have you ever had any problems or complications with previous dental treatment? ❒ YES ❒ NO
    If yes, explain: ______
15. Do you clench or grind your teeth? ❒ YES ❒ NO
16. Does your jaw click or pop? ❒ YES ❒ NO
17. Have you experienced any pain or soreness in the muscles or your face or around your ear? ❒ YES ❒ NO
18. Do you have frequent headaches, neckaches or shoulder aches? ❒ YES ❒ NO
19. Does food get caught in your teeth? ❒ YES ❒ NO
20. Are any of your teeth sensitive to: ❒ Hot? ❒ Cold? ❒ Sweets? ❒ Pressure?
21. Do your gums bleed or hurt? ❒ YES ❒ NO
    When? ______
22. How often do you brush your teeth? ______ When? ______
23. Do you use dental floss? ❒ YES ❒ NO
    How often? ______
24. Are any of your teeth loose, tipped, shifted or chipped? ❒ YES ❒ NO
25. Are you unhappy with the appearance of your teeth? ❒ YES ❒ NO
26. How do you feel about your teeth in general? ______
27. Do you feel your breath is offensive at times? ❒ YES ❒ NO
28. Have you ever had gum treatment or surgery? ❒ YES ❒ NO
    What? ______
    Where? ______
    When? ______
29. Have you had any orthodontic work? ______
30. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? ______
31. Do you have any questions or concerns? ❒ YES ❒ NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE ______ DATE ______

DENTIST'S SIGNATURE ______ DATE ______

ANEST.

MED.ALERT

DENTAL HISTORY

Fonn No. T15ODH

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welcome

PATIENT NUMBER

Patient's Name ______ Last ______ First ______ Initial ______ Date of Birth ______

CIRCLE THE APPROPRIATE ANSWER, IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW ON THE LINE AFTER THE QUESTION

1. Physician's Name ______
   Address ______
   City ______ State ______ Zip ______ Tel ______
2. Are you under a physician's care? ❒ YES ❒ NO
   Since when ______ Why ______
3. When was your last complete physical exam? ______
4. Are you taking any medication or substances? ❒ YES ❒ NO
   (if yes, please list medications in comments section or on the back of this form.)
5. Do you routinely take health related substances?- ❒ YES ❒ NO
6. Are you allergic to any medications or substances? (please list) ❒ YES ❒ NO
7. Do you have any other allergies or hives? ❒ YES ❒ NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? ❒ YES ❒ NO
9. Are you sensitive to any metals or latex? ❒ YES ❒ NO
10. Are you pregnant or suspect you may be? ❒ YES ❒ NO
11. Do you use any birth control medications? ❒ YES ❒ NO
12. Have you ever been treated for or been told you might have heart disease? ❒ YES ❒ NO
13. Do you have a pacemaker or an artificial heart valve implant? ❒ YES ❒ NO
14. Have you ever had rheumatic fever? ❒ YES ❒ NO
15. Are you aware of any heart murmurs? ❒ YES ❒ NO
16. Do you have high or low blood pressure? (please circle) ❒ YES ❒ NO
17. Have you ever had a serious illness or major surgery? ❒ YES ❒ NO
    If so, explain ______
18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? ❒ YES ❒ NO
19. Do you have inflammatory diseases, such as arthritis or rheumatism? ❒ YES ❒ NO
20. Do you have any artificial joints/prosthesis? ❒ YES ❒ NO
21. Do you have any blood disorders, such as anemia, leukemia, etc? ❒ YES ❒ NO
22. Have you ever bled excessively after being cut or injured? ❒ YES ❒ NO
23. Do you have any stomach problems? ❒ YES ❒ NO
24. Do you have any kidney problems? ❒ YES ❒ NO
25. Do you have any liver problems? ❒ YES ❒ NO
26. Are you diabetic? ❒ YES ❒ NO
27. Do you have fainting or dizzy spells? ❒ YES ❒ NO
28. Do you have asthma? ❒ YES ❒ NO
29. Do you have epilepsy or seizure disorders? ❒ YES ❒ NO
30. Do you or have you had venereal disease? ❒ YES ❒ NO
31. Have you tested HIV positive? ❒ YES ❒ NO
32. Do you have AIDS? ❒ YES ❒ NO
33. Have you had or do you test positive for hepatitis? ❒ YES ❒ NO
34. Do you or have you had T.B.? ❒ YES ❒ NO
35. Do you smoke, chew, use snuff or any other forms of tobacco? ❒ YES ❒ NO
36. Do you consume alcoholic beverages? ❒ YES ❒ NO
37. Do you habitually use controlled substances? ❒ YES ❒ NO
38. Have you had psychiatric treatment? ❒ YES ❒ NO
39. Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? ❒ YES ❒ NO
40. Do you have any disease condition, or problem not listed? If so, explain
    ______
41. Is there anything else we should know about your health that we have not covered in this form?
    ______
42. Would you like to speak to the Doctor privately about any problem? ❒ YES ❒ NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE ______ DATE ______

DENTIST'S SIGNATURE ______ DATE ______

ANEST.

MEDICAL HISTORY

MED.ALERT

Fonn No. T14OMH

Hemet West Dental Office

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SECTION A: The Patient.

Name: ______________________________

Address: ______________________________

Telephone: ______________________________ E-mail: ______________________________

Patient Number: ______________________________ Social Security Number: ______________________________

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice.

I ______________________________, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: ______________________________ Date: ______________________________

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: ______________________________

Relationship to Individual: ______________________________

SECTION C: Good Faith Effort to Obtain Acknowledgement of Receipt.

Describe your good faith effort to obtain the individual's signature on this form:

____
____
____
____

Describe the reason why the individual would not sign this form:

____
____
____
____

SIGNATURE.

I attest that the above information is correct.

Signature: ______________________________ Date: ______________________________

Print name: ______________________________ Title: ______________________________

Include this acknowledgement of receipt in *the* individual's *records.*

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

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