PATIENT REGISTRATION

ID:____________________ Chart ID:____

First Name:____________________________________ Last Name:____________________________________ Middle Initial:__________________

Patient is: ☐ Policy Holder ☐ Responsible Party ☐ Preferred Name:

RESPONSIBLE PARTY (If someone other than the patient)

First Name:____________________________________ Last Name:____________________________________ Middle Initial:__________________

Address:____ Address 2:____

City:____ State:_________________ Zip: ____

Home Phone:____________________ Work Phone:___________________ Ext:_________ Cell Phone: ___________________________________

Birth Date:_____________________________ Soc Sec:______________________________ Drivers License:______________________________

☐ Responsible Party ☐ Primary Insurance ☐ Policy Holder ☐ Secondary Insurance Policy Holder

PATIENT INFORMATION

Address:____ Address 2:____

City:____ State:_________________ Zip: ____

Home Phone:____________________ Work Phone:___________________ Ext:_________ Cell Phone: ___________________________________

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: ____________________ Age:__________ Soc Sec: ______________________________ Drivers License: _______________________

E-mail:____ ☐ I would like to receive correspondence via e-mail.

EMPLOYMENT STATUS: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time Referred By:___________________________________

Medicaid ID:__________________________ Pref. Dentist:__________________________ Previous Dentist:______________________________

Employer ID:__________________________ Pref. Pharmacy:________________________ Emergency Contact:____________________________

Carrier ID:___________________________ Pref. Hyg:_____________________________ Emergency Contact #: __________________________

PRIMARY INSURANCE INFORMATION

Name of Insured:_______________________________________ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: ____ Insured Birth Date: ____

Employer: ____ Ins. Company: ____

Address:____ Address:____

Address 2:____ Address 2:____

City:__________________ State:__________ Zip:__________________ City:__________________ State: _________ Zip: __________________

Rem. Benefits:____ Rem. Deduct: ____

SECONDARY INSURANCE INFORMATION

Name of Insured:_______________________________________ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: ____ Insured Birth Date: ____

Employer: ____ Ins. Company: ____

Address:____ Address:____

Address 2:____ Address 2:____

City:__________________ State:__________ Zip:__________________ City:__________________ State: _________ Zip: __________________

Rem. Benefits:____ Rem. Deduct: ____

MEDICAL HISTORY

Patient Name ______________________________ Birthday ______________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Heath problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain:______________________

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain:______________________

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain:______________________

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain:______________________

Do you take, or have you taken, Fen-Phen or Redux? ☐ Yes ☐ No

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

Are you on a special diet? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled Substances? ☐ Yes ☐ No

WOMEN: Are you

Pregnant / trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Late ☐ Sulfa drugs

☐ Other - Please explain: ______________________

DO YOU HAVE, OR HAD, ANY OF THE FOLLOWING

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

Have you ever had any serious illness not listed above? ☐ Yes ☐ No

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 me (or patient) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient (parent / guardian if patient is a minor)______________________ Date: ______________

DENTAL TREATMENT CONSENT FORM

Please read and initial the items checked below, read and sign the section at the bottom of the form.

Patient's name: ______________________________ Date: ______________

______ Initials
1. WORK TO BE DONE
I understand that I am having the following work done: Fillings | Bridges | Crowns | Extractions | Dentures | Root canals | Impacted teeth removed | General Anesthesia | X-rays | Periodontal Treatment | Other

______ Initials
2. DRUGS AND MEDICATIONS
I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness, 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 add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures, I give permission to the Dentist to make an 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 steps necessary in paragraph 3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, 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 the following treatment, the cost of which is my responsibility.

______ Initials
5. CROWNS, 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 I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure 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 (shape, fit, size, and color) will be before cementation. It is my responsibility to return for permanent cementation within 30 days from teeth preparation. Excessive delays may allow for tooth movement and may necessitate a remake of the crown, bridge or cap. I understand there will be additional charges for remakes due to my delaying permanent cementation.

______ Initials
6. DENTURES, COMPLETE AND PARTIAL
I realize that full or partial dentures are artificial, constructed of plastics, metal and or porcelain. The problems of wearing this appliance has been explained to me, including looseness, soreness and or possible breakage. I realize that the final opportunity to make changes to my new denture (including shape, fit, size, placement and color) will be the “teeth in wax” visit. I understand that most dentures require relining approximately three to twelve months after the initial placement. The cost of this procedure is not included in the initial denture fee. I understand the wearing of the dentures is difficult, sore spots, altered speech and the difficulty in eating are common problems, Immediate dentures (placement of denture immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for the delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of more than 30 days there will be additional charges that I will be responsible for.

______ Initials
7. ENDODONTIC TREATMENT (ROOT CANAL)
I realize that there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are broken in the tooth or perforate the tooth and that occasional root canal filling material may extend through the root, which does not necessarily affect the success of the treatment. I understand that endodontic files and reamers are very fine instruments and stresses vented in their manufacture can cause them to separate during use. I understand that the tooth may be lost despite all the efforts to save it.

______ Initials
8. PERIODONTAL LOSS (TISSUE AND BONE)
I understand that I have a serious condition, causing gum and bone infections or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal conditions

______ Initials
9. FILLINGS
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 fillings than that originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filing.

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 have 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. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me, I also understand that no other dentist or dental group is responsible for my dental treatment. I hereby authorize any of the doctors or dental auxiliaries of Park Centre Dental Office to proceed with, and perform the dental restorations and treatments as explained to me. I understand that this is only as estimate and subject to modifications depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney fees, collections fees or court costs that may be incurred to satisfy this obligation. Should any dispute arise over dental services provided to me, that is whether any dental service rendered as allegedly unnecessary, unauthorized or was improperly, negligently or incompletely performed, said dispute will be submitted to peer review by the local component of the American Dental Association, The decision of the Peer Review shall be binding by both parties. I have read, understood and agree to the above. I agree that a photocopy of this authorization shall be a valid and effective as the original forever. I am of legal age and legally competent to make this assignment.

Signature of patient (parent / guardian if patient is a minor) ______________________ Date: ______________

Park Centre Family Dental Office
15401 Anacapa Rd, Ste 3
Victorville, CA 92392
(760) 951-9304

HIPAA Consent and acknowledgment form

I do hereby consent and acknowledge my agreement to the terms set forth in the “HIPAA Information Form” and any subsequent changes in Office Policy. I understand that this consent and acknowledgment shall remain in force indefinitely.

Patient / Guardian ____ Date ______________________________

Dental Materials Fact Sheet

Effective January 1st, 2002 , dentists are required by the State of California to provide a copy of the Dental Materials facts sheet to any patient who will be receiving restorative treatment. This conformation of receipt for must be signed by the fact sheet. It is not an informed consent document and the Sate of California does not endorse the information nor does it recommend a particular course of treatment, it is a matter that remains to be discussed between the patients and his / her dentist. This information contained on the fact sheet is simply intended to educate patients on the various types of materials used by dentists during the course of restorative dental treatment, in a similar manner to package labeling found on most food. I acknowledge that I received from Park Centre Family Office a copy of the “Dental Materials Facts Sheet” dated October 2001.

Patient / Guardian ____ Date ______________________________

If unable to keep your appointment, kindly give us a 24 hour notice in advance, as this is reserved exclusively for you. For cancellation, we have an office policy or a $25.00 charge to your account. Your consideration is greatly appreciated.

Patient / Guardian ____ Date ______________________________

All payments are requested on the day of your visit when services are done. We greatly appreciate your timely payments.

Patient / Guardian ____ Date ______________________________