South Coast Dental Center

Patient Information

Date:_____

Patient_____
Last name First name Middle name Preferred name

Address_____City_____State_____Zipcode_____

Home Phone _____ Cell Phone_____

Email _____Sex: ☐ M ☐F

Age _____ Date of Birth _____ ☐ Single ☐Married ☐Widowed ☐Separated ☐Divorced

Employer_____Occupation_____

Business Address _____ Business Phone_____

Spouse Name _____Spouse Birthdate_____

Spouse Employed by_____Occupation_____

Business Address_____ Business Phone _____

Who is the subscriber of the insurance?_____ Relationship to patient _____

Social Security # _____Spouse's Social Security #_____

Insurance company name_____ Member ID _____

In case of emergency, who should be notified?_____ Phone # _____

Whom may we thank for referring you?_____

Medical History

Physician's Name _____ Date of Last Physical _____

Have you ever had any of the following? (check the boxes that apply):

☐Heart Problems
☐High Blood Pressure
☐Low Blood Pressure
☐"A.I.D.S" or other Immunosuppressive Disorder
☐Chronic Diarrhea
☐Allergies to Anesthetics
☐Allergies to Medicine or Drugs
☐General Allergies
☐Blood Disease
☐Arthritis
☐Epilepsy
☐Headaches
☐Hepatitis, Jaundice or Liver Disease
☐Cancer
☐Psychiatric Care
☐Stroke
☐Ulcer
☐Venereal Disease
☐Chemical Dependency
☐Hemophilia
☐Respiratory Disease
☐Swollen neck glands
☐Rheumatic fever
☐Sinus Problems
☐Circulatory Problems
☐Nervous Problems
☐Radiation Treatment
☐Artificial Heart Valves
☐Recent Weight Loss
☐Back problems
☐Diabetes
☐Special Diet

Do you have any drug allergies or have you ever had an adverse reaction to any medication?_____ If so, what?_____
Have you ever responded adversely to medical or dental treatment?_____

Are you taking any medication at this time?_____ If so, what?_____

Are you under the care of a physician? ⬜Yes ⬜No

For what conditions?_____

If the patient is a child, what is his/her weight?_____
(Woman) Do you suspect that you are pregnant? ⬜Yes ⬜No Are you nursing? ⬜Yes ⬜No

Is there anything else we should know about your medical history?_____

Dental History

What will we be helping you with today?:_____

Date of last exam _____ Any previous major dental treatment? ⬜ Yes ⬜No When?_____

Do you have or use any of the following? (check the boxes that apply):

⬜Teeth sensitive to cold, heat, sweets or pressure
⬜Swelling or lumps in mouth
⬜Unusual sounds while eating
⬜Unfavorable dental experience
⬜Orthodontic treatment
⬜Frequency of brushing _____
⬜Water jet device
⬜Bleeding gums. How long? _____
⬜Clenching or grinding
⬜Frequent blisters on lips or mouth
⬜Bad breath
⬜Complications from extractions
⬜Mouth Breathing
⬜Dental Floss
⬜Disclosing tablet or solution
⬜Food impaction
⬜Burning of tongue
⬜Pain around ear
⬜Unpleasant taste
⬜Periodontal treatment
⬜Cigarettes, pipe or cigar smoking
⬜Interdental stimulators
⬜Oral habits e.g. fingernail biting, cheek biting, etc.

Medical History Update

Date	Medical Changes	Patient Signature	Dr. Signature

I approve that all the information above is true and has been filled out to the best of my ability.

Signture:_____Date:_____

Doctor Signature:_____Date:_____

DENTAL TREATMENT CONSENT FORM

Please read and initial items checked below
And read and sign the section at the bottom of form. Patient Name _____

☐ **1. DIAGNOSTIC AND PREVENTIVE**
I understand that I am having the following work done: Xrays_____Cleaning_____ Scaling_____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 reaction).
(Initials_____)

☐ **3. NITROUS OXIDE**
I understand that nitrous oxide (laughing gas) provides relaxation to make it more comfortable for me to receive the necessary dental care with less anxiety. I will be awake, fully conscious, aware of my surroundings, and able to respond rationally. I have informed the doctor of my complete medical history including any recent surgeries or changes in my medical history.
(Initials_____)

☐ **4. LOCAL ANESTHETIC**
I understand there are risks of local anesthesia that may affect my body such as dizziness, nausea, vomiting, accelerated heart rate, slow heart rate, or various types of allergic reactions. It may also cause injury to nerves that can result in pain, numbness, tingling that may persist for several weeks, months, or rarely, be permanent. I have informed my doctor of my complete medical history including any recent surgeries or changes in my medical history.
(Initials_____)

☐ **5. REMOVAL OF TEETH**
Alternatives to removal have been explained to me and I authorize the dentist to remove the following teeth _____. I understand that 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, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue 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 hospitalization if complications arise during or following treatment, the cost of which is my responsibility.
(Initials_____)

☐ **6. CROWNS AND BRIDGES**
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 or bridge will be before cementation.
(Initials_____)

☐ **7. 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 looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures 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 for this procedure is not included in the initial denture fee.

(Initials_____)

☐ **8. ENDODONTIC TREATMENT (ROOT CANAL)**

I realize 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 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).

(Initials_____)

☐ **9. We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided. I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee has been made by anyone regarding the dental treatment by 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 or legal guardian _____Date_____

HIPPA PATIENT CONSENT FORM

Our Notice of Privacy Practice provides information about how we may use and disclose protected health information about you. The Notice contains a patient rights section describing your rights under the law. You have the right to review our notice before signing this consent the terms of our notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The Patient has the right to restrict the uses if their information but the practice does not have to agree to the restrictions.
- The Patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

This Consent was signed by:_____

Date:_____

NON-COVERED SERVICES CONSENT FORM
HITECH ACT OF 2009

I understand that not all dental services are covered by my insurance plan and are not included as part of another service. These services include, but are not limited to, advanced dental material fees, upgrades, lab cost, implants, bone graft, membrane, as examples.

- I choose to receive these specific services.
- I agree to pay for these specific services.
- All alternative procedures were explained to me in detail.

I knowingly understand that the listed dental procedures may not be covered (paid) by my insurance plan because the procedures may not be considered medically or dentally necessary.

The Dental office has explained to me, and I understand:

- Why the procedures are needed.
- How much the procedures will cost.
- What methods I can use to pay for the procedures not covered by my plan.
- When I must pay the cost.

Signature_____ Date_____

Print Name_____

South Coast Dental Center
3500 S. Bristol St., Suite #101
Santa Ana, CA 92704
714-556-1717

Patient Financial Agreement

- **Payment: Our office requires full payment or insurance co-payment at the time of service unless previous financial arrangements are made.**

- **Insurance:** As a courtesy to our patients, we will bill your insurance on your behalf, but ultimately it is the patient's responsibility to pay for the amount of the services rendered by our office. If the account is 60 days past due, a finance charge of 1.5% per month or 18% APR will be charged until account is paid in full.

- We accept **Credit Cards** for payment: **Visa, Master Card, American Express, and Discover.**

- We offer **Care Credit, Greensky, & Lending Club: P**ayment plans with **0% interest for 6 or 12 months** on approved credit.

- We accept **Personal Checks**: But in the event that the check is returned for insufficient funds, there is a $25 returned check fee.

- **Appointments**: A minimum charge of $75 will be made for the failed or a canceled appointment without prior notification of 24 hours. This fee covers only a portion of the overhead such as salaries, rent, etc., which still has to be paid. Once an appointment is made, **please remember the date and time has been reserved for you; kindly give us an advance notice.**

We, at South Coast Dental Center appreciate your business. Please let us know if you need any help or have additional questions to be answered.

Thank you in advance for your cooperation.

Signature_____Date_____
(Patient or Guardian if patient is a minor)