PERFECT SMILES
FAMILY DENTISTRY

Confidential Information

1 Patient Information

Name: .....

I prefer to be called: ..... ☐ Male ☐ Female

Date of Birth: ..... SSN: .....

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Minor

Home Address: .....

.....

Email: ..... ☐

Home: ..... ☐ Cell: ..... ☐

Work: ..... ☐ Profession: _____

Employer/School: .....

Employer/School Address: .....

.....

Spouse/Guardian's Name: .....

Whom may we thank for referring you? .....

☐ Yellow Pages ☐ Magazines ☐ Mailers ☐ Friend
☐ Family ☐ Yahoo! ☐ Google ☐ Other

2 Responsible Party

Person Responsible for this Account: .....

Relationship to Patient: .....

Date of Birth: ..... SSN: .....

Address: .....

.....

Email: ..... ☐

Home: ..... ☐ Cell: ..... ☐

Work: ..... ☐

Driver's License: ..... Employer: .....

Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer.

☐ Cash ☐ Personal Check ☐ Visa ☐ MasterCard
☐ Health Loan Service ☐ I wish to discuss the office's payment policy

Emergency Contact Name: .....

Home: ..... ☐ Work: ..... ☐

3 Insurance Information

Primary Insurance

Name of Insured: ..... Relationship to Patient: .....

Birthdate: ..... SSN: ..... Date Employed: .....

Employer: ..... Union or Local#: ..... Employer's Phone: .....

Employer's Address: ..... City/States/Zip: .....

Insurance Company: ..... Group/Policy/ID#: ..... Insurance Co. Phone: .....

Insurance Co. Address: ..... City, States, Zip: .....

Secondary Insurance

Name of Insured: ..... Relationship to Patient: .....

Birthdate: ..... SSN: ..... Date Employed: .....

Employer: ..... Union or Local#: ..... Employer's Phone: .....

Employer's Address: ..... City/States/Zip: .....

Insurance Company: ..... Group/Policy/ID#: ..... Insurance Co. Phone: .....

Insurance Co. Address: ..... City, States, Zip: .....

Signature on file:
Perfect Smiles Family Dentistry is authorized to provide any insurance company(s), claim administrator(s) and consulting health care professionals, information concerning health care advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits.

X _____ Date: _____

Patient or authorized person's signature

Confidential Information

4 Patient Medical History

	Yes	No
1. Do you have a personal physician?	☐	☐
a) Physician's Name: _____		
b) Physician's Office Phone: _____		
c) Date of Last Exam _____		
2. Are you under medical treatment now?	☐	☐
3. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	☐	☐
4. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	☐	☐
5. Have you ever taken Fen-Phen/Redux?	☐	☐
6. Do you use tobacco?	☐	☐
7. Do you use controlled substances?	☐	☐

	Yes	No
9. Do you use contact lenses?	☐	☐
10. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____	☐	☐
11. Do you have a persistant cough or throat clearing not associated with a known illness? (lasting more than 3 weeks)	☐	☐
12. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

8. Do you have or have you ever had any of the followings?

	Yes	No		Yes	No		Yes	No
AIDS or HIV Infection	☐	☐	Glaucoma	☐	☐	Mitral Valve Prolapse	☐	☐
Anemia	☐	☐	Hay Fever / Allergies	☐	☐	Radiation Therapy	☐	☐
Angina	☐	☐	Heart Attack	☐	☐	Recent Weight Loss	☐	☐
Arthritis	☐	☐	Heart Murmur	☐	☐	Respiratory Problems	☐	☐
Asthma	☐	☐	Heart Disease	☐	☐	Rheumatic Fever	☐	☐
Cancer	☐	☐	Heart Trouble	☐	☐	Sexually Transmitted Disease	☐	☐
Cardiac Pacemaker	☐	☐	Hepatitis / Jaundice	☐	☐	Shortness of Breath	☐	☐
Chest Pains	☐	☐	High Blood Pressure	☐	☐	Stomach Troubles / Ulcers	☐	☐
Diabetes	☐	☐	Joint Replacement / Implant	☐	☐	Stroke	☐	☐
Emphysema	☐	☐	Kidney Diseases	☐	☐	Swollen Ankles	☐	☐
Epilepsy / Convulsions	☐	☐	Leukemia	☐	☐	Tuberculosis	☐	☐
Fainting / Seizures	☐	☐	Liver Disease	☐	☐	Thyroid Problem	☐	☐
Frequently Tired	☐	☐	Low Blood Pressure	☐	☐	Other _____	☐	☐

5 Patient Dental History

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do any of your teeth hurt?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck, or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you seen an orthodontist for treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, how old are they? _____	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

I certify that I have read and understand the above. The above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information can be harmful to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to **Perfect Smiles Family Dentistry** or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

X _____ Date: _____

Signature of patient (or parent/guardian if minor)

Doctor's Comments: _____

_____ Date: _____

_____ Date: _____

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[ ] ***HIPAA***

I consent to the use and disclosure of my protected health information to carry out treatment. payment activities, and healthcare operations by PSFD. I have the right to read the Notice of Privacy Practices before deciding to sign this Consent. This Notice provides a description of the uses and disclosures taken to my protected health information, and of other important matters about my protected health information. '
I also have the right to revoke this Consent at any time by giving PSFD written notice of revocation submitted to the office manager or treatment provider. .(Note: Revocation of this Consent will not affect any action taken in reliance on this Consent before receiving the revocation,and that PSFD may decline to give treatment or \0 continue treatment once this Consent is revoked.)

[ ] ***CONSENT FOR TREATMENT***

I hereby authorize PSFD *and/or* designated staff to take radiographs, study models, photographs, and any other diagnostic aids deemed appropriate by a doctor to make a thorough diagnosis.
Upon such diagnosis, I authorize Dr. David P. Cartago and other PSFD Provider(s} ':0 perform all recommended treatment mutually agreed upon by me and to employ such assistance as required for proper care.
I agree to the use of anesthetics, sedatives, or other medication as necessary. I fully understand that using anesthetics agent embodies certain risks. I understand that I can ask for complete recital of any possible complications.

[ ] ***ASSIGNMENT AND RELEASE***

I certify that I, and f or my dependents), have insurance coverage indicated on the Patient Registration, and assign directly to Dr. David P. Cartago, Perfect Smiles Family Dentistry all insurance benefits, if any. otherwise oayable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. PSFD may also use my health care information and may disclose such information to the Insurance Company(ies} and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date of my last treatment.

[ ] ***DENTAL MATERIALS FACT $HEET***

I acknowledge that I have received the Dental Materials Fact Sheet developed by the Dental Board of California. I understand that this sheet has been provided to me in an effort to ensure I am fully informed of the variety of materials available for dental restorations. I understand that I should review this information to make a fully informed decision regarding dental restorative treatment. I also understand that if I have questions or concerns regarding this information that it is my right to have a discussion regarding this aspect of my care with the dentists.

[ ] ***I ACKNOWLEDGE UNDERSTANDING AND ACCEPTANCE*** **OF** ***THE FOLLOWING OFFICE POLICIES****:*

(24-Hour Cancellation Policy) :: Each patient is required to provide advanced notice to allow PSFD to arrange office schedules. Failure to notify any cancellation of appointments 24 hours in advance will result in a *$25lhour fee.* Three such incidents shall be considered as automatic noncompliance and withdrawal of dental treatment.

(Payments):: Co-payments and/or Payments are due when Services are rendered. An estimate of your financial responsibilities shall be provided prior to or during your visit. If you did not receive an estimate, a copy shall be made immediately upon request.

(Insurance Claims) :: We are NOT contracted with your insurance company(ies} and therefore have no authority over eligibility, benefits, fee schedules, or other membership entitlements. Thus as a courtesy, PSFD will process insurance claims on your behalf, but you are still responsible for the payments of services rendered. Any claims outstanding after 60 days will be billed directly to you. Any unpaid balances after 60 days will be submitted to Collections.

(Information Update) :: Each patient is responsible for updating any changes to health, medication, insurance coverage, and/or personal

Patient/Guardian Signature_____ **Today's Date**_____

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Patient Acknowledgment of Receipt of Dental Materials Fact Sheet and Notice of Privacy Practices

As of January 1, 2002, the Dental Board of California now requires that we distribute to our patients a copy of the Dental Materials Fact Sheet. In addition, the Heath Insurance Portability and Accountability Act (HIPAA) requires effective April 14, 2003 that patients be given a copy of our Notice of Privacy Practice.

If you would, please print and sign your name below.

I_____ , acknowledge I have received from this office

1. A copy of the Dental Materials Fact Sheet; and

2. Notice of Privacy Practices.

_____ _____

Patient Signature or Personal Representative Date .

If signed by a Personal Representative of the Patient, describe the representative's authority to act for the patient. .

For Office Use

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communications barriers prohibited obtaining acknowledgement
- o An emergency situation. prevented us from obtaining acknowledgement
- o Other (Please Specify)

_____
_____
_____