WELCOME

Rancho Niguel Dental Group

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1. ABOUT YOU

Today's Date: _____/_____/_____ File #____
Patient Name: _____
Last First MI
What You Prefer To Be Called: _____
Male Female
Birthdate: _____/_____/_____ Age: _____
SS #:_____
Preferred Language: _____
Mailing Address: _____
City: _____ State: ____ Zip: ____
Home Phone #: _____
Work Phone #: _____ Ext: ____
Cell Phone #: _____
Email: _____
Referred By: _____
Employer: _____ How long? ___
Employer's Address: _____
_____
Occupation: _____
Divorced Married Single Widowed Minor
Spouse's Name: _____
Do you have children? How many?_____

2. INSURANCE INFO

Primary Dental Insurance
Co. Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Phone #: _____
Insured's SS#: _____
Group # (Plan, Local, or Policy #): _____
Insured's Name: _____
Relation: _____ Birthdate: ___/_____/_____
Insured's Employer: _____

Secondary Dental Insurance
Co. Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Phone #: _____
Insured's SS#: _____
Group # (Plan, Local, or Policy #): _____
Insured's Name: _____
Relation: _____ Birthdate: ___/_____/_____

3. ACCOUNT INFO

Person ultimately responsible for account
Name: _____
Relation: _____
Billing Address: _____
City: _____
State: _____ Zip: _____
SS #: _____
Driver's License #: _____
Work Phone #: _____

_____ (Initials) I here by authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

4. IN EVENT OF EMERGENCY

Whom should we contact? _____
Relation: _____
Home Phone #: _____
Work Phone #: _____
Who is your Medical Doctor? _____
M.D.'s Phone #: _____

5. DENTAL INFO

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation Are you in pain? ☐ Yes ☐ No Length?___

Please indicate ☐ any of the following problems:

- ☐ Discomfort, clicking, or popping in jaw.
- ☐ Red, swollen or bleeding gums.
- ☐ Sensitive tooth, teeth, or gums.
- ☐ Blisters/Sores in or around the mouth.
- ☐ Lost/Broken filling(s)
- ☐ Teeth grinding
- ☐ Ringing in ears
- ☐ Broken/chipped tooth
- ☐ Stained teeth
- ☐ Locking jaw
- ☐ Bad breath

Other: _____

Do you require pre-medication ☐ Yes ☐ No ☐ Don't know

Previous Dentist: _____ Phone #: _____

Last Dental Exam: _____/ _____/ _____ Last Dental X-Rays: _____/ _____/ _____

Times a day you brush? _____ Times a week you floss? _____

What type of tooth brush bristles do you use? ☐ Soft ☐ Medium ☐ Hard

How would you rate your smile ? 1 2 3 4 5 6 7 8 9 10

6. MEDICAL HISTORY

Have you taken any medication or drugs the past two years? Yes No

Are you taking any medication, drugs, or pills now? Yes No

If yes please list name and dosage _____

Have you ever taken/do you take any of the following? (circle all that apply)

Recreational Drugs	Tobacco in any form	Antibiotics
Over-the-counter medicines	Alcohol	Supplements
Weight loss medications	Bisophosphonate (Fosamax)	Aspirin

Are you aware of having an allergic (**or adverse**) reaction to any medication or substance? Yes No

If yes, please list: _____

Have you been a patient in the hospital during the past five years? Yes No

Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (surgery, disease, attack)	Yes	No	Ulcers	Yes	No	Hepatitis A (Infectious) B (Serum)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact Lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artifical Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

Do you use more than two pillows to sleep?_____

Have you lost or gained more than 10 pounds in the past year?_____

Do you have or have you had any disease, condition, or problem not listed?_____

If yes, please list:_____

Women: Pregnant? Yes, ____ Months **Nursing?** Yes No **Taking birth control pills?** Yes No

I certified that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health, and/or medication. Further, I will not hold my dentist, or any member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature of Patient (Parent or Guardian) Date Signature of Doctor Date

XII. MEDICAL UPDATES

I have reviewed my health history and confirm that it accurately states past and present conditions

Date	Patient Signature:	Changes to health history	Dentist Int
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

RANCHO NIGUEL DENTAL GROUP

DENTIST

PATIENT

❶ WORK TO BE DONE

I understand that I am having the following work done: ○ Fillings_____ ○ Crowns_____ ○ Extractions_____ ○ Dentures_____
○ Impacted Teeth Removed_____ ○ Root Canals_____ ○ Periodontal Treatment_____ ○ Other_____

❷ DRUGS, MEDICATIONS, AND X-RAYS

I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. X-Rays are taken by qualified personnel. Exposure to X-Ray radiation (minimal). X-Ray pictures remain the property of this office. Full mouth series of X-Rays may be necessary to aid in diagnosing future dental treatment.

❸ CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions that were not discovered during examination but were found while working on the teeth. For example, root canal therapy may be discovered to be needed during routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

❹ CROWNS, BRIDGES, AND OTHER DENTAL CASTINGS

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 (including the shape, fit. size, and color) will be before cementation. It is also my responsibility to return for permanent cementation within 20 days from tooth preparation Excessive delays may allow for tooth movement. This 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.

❺ 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 filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling.

❻ 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 root canal filling material may extend through the tooth which does not necessarily effect 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 occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost despite all effort to save it.

❼ 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 others necessary for reasons 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, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue, or fractured jaw. I understand removal of teeth can result in paraesthesia that can last permanently or for an indefinite period of time, and that paraesthesia numbness is a possible risk of injection/extraction. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.

❽ PERIODONTAL LOSS (TISSUE AND BONE)

I understand that I have a serious condition causing gum and bone inflammation 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 condition.

❾ DENTURES

I understand the wearing of dentures is difficult. Sore spots, altered speech, and 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 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.

❿ DENTAL MATERIALS FACT SHEET ACKNOWLEDGMENT

Rancho Niguel Dental Group made the Dental Materials Fact Sheet available to me to read in the office and/or take home. I acknowledge that this was made readily available for me and I have chosen to or not to read this material.

I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot properly 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 understand that no other Dentist is responsible for my dental treatment.

I hereby authorize any of the doctors or dental auxiliaries to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification 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's fees, collection fees, or court costs that may be incurred to satisfy this obligation.

I understand that this practice provides space, equipment, support personnel and administrative services to allow each dentist to focus on patient care. The individual dentists practicing at this practice are not agents or employees of this practice. Each of them exercises independent professional judgement in the nature and manner of dental care and treatment provided. I ACKNOWLEDGE THAT I AM AWARE THAT ALL OF THE DENTISTS ARE NOT EMPLOYEE AGENTS OF THIS DENTAL MANAGEMENT COMPANY.

X_____ DATE_____
SIGNATURE OF PATIENT

X_____ WITNESS_____
SIGNATURE OF DOCTOR

X_____ DATE_____
PLEASE PRINT NAME, IF A MINOR, PLEASE PRINT THE MINORS NAME

X_____ DATE_____
SIGNATURE ☐ *PARENT / GUARDIAN* ☐ *SPOUSE*

If the patient is under the age of 18 years old, please have a parent or legal guardian sign this form.

❹ *CROWNS, BRIDGES, AND OTHER DENTAL CASTINGS*

DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR
DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR
DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR
DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR
DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR
DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR
DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR
DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR
DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR

❺ *FILLINGS*

TOOTH NUMBER	PAT INIT	MO.	DAY	YR	TOOTH NUMBER	PAT INIT	MO.	DAY	YR
TOOTH NUMBER	PAT INIT	MO.	DAY	YR	TOOTH NUMBER	PAT INIT	MO.	DAY	YR
TOOTH NUMBER	PAT INIT	MO.	DAY	YR	TOOTH NUMBER	PAT INIT	MO.	DAY	YR
TOOTH NUMBER	PAT INIT	MO.	DAY	YR	TOOTH NUMBER	PAT INIT	MO.	DAY	YR
TOOTH NUMBER	PAT INIT	MO.	DAY	YR	TOOTH NUMBER	PAT INIT	MO.	DAY	YR

❻ *ENDODONTIC TREATMENT (ROOT CANAL)*

TOOTH NUMBER	PAT INIT	MO.	DAY	YR	TOOTH NUMBER	PAT INIT	MO.	DAY	YR
TOOTH NUMBER	PAT INIT	MO.	DAY	YR	TOOTH NUMBER	PAT INIT	MO.	DAY	YR
TOOTH NUMBER	PAT INIT	MO.	DAY	YR	TOOTH NUMBER	PAT INIT	MO.	DAY	YR

❼ *REMOVAL OF TEETH*

TOOTH NUMBER	PAT INIT	MO.	DAY	YR	TOOTH NUMBER	PAT INIT	MO.	DAY	YR
TOOTH NUMBER	PAT INIT	MO.	DAY	YR	TOOTH NUMBER	PAT INIT	MO.	DAY	YR
TOOTH NUMBER	PAT INIT	MO.	DAY	YR	TOOTH NUMBER	PAT INIT	MO.	DAY	YR

❶ *OTHER PROCEDURES*

DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR
DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR
DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR
DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR
DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR