Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # _____

SS#/SIN _____

Date _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Email _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College _____ City _____ State/Prov. _____ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS#/SIN _____

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. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Over Please

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐
9. Do you have or have you had any of the following?		

	Yes	No
10. Are you wearing contact lenses?	☐	☐
11. 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) _____		
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
13. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

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

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	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 you feel pain to any of your teeth?	☐	☐
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 had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous 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 the dentist 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 my dependents.

X _____

Signature of patient (or parent/guardian if minor) Date

Doctor's Comments _____

_____

_____ Signature _____ Date _____

ORCUTT HILLS DENTAL STUDIO, FINANCIAL POLICY

We believe that clear communication concerning financial arrangements is vital in order to establish a mutually satisfactory understanding. If at any time you have questions or concerns regarding fees, please feel free to talk with us about them.

- For patients without insurance coverage, payment in full is required at time of service. We accept all major credit cards, check and cash.
- We offer outside financing through Care Credit which has plans which can be tailored to meet the patients' needs.
- Co-pays and deductibles are paid at time of service.
- The design of your insurance plan may limit the amount insurance will reimburse. Any financial information provided to you prior to the insurance payment is an **ESTIMATE**. Your actual portion due may change after insurance has paid its portion.
- There may be an additional amount due for any additional procedure not include in the original treatment plan.
- For patients with insurance coverage, it is important that you are aware that some services and procedures are not covered by your plan. Patient is responsible for any unpaid balance after insurance claims are all processed.
- Should benefit confirmation be obtained, it is not a guarantee of payment. Claims must be submitted and reviewed before final payment determination is made by the insurance company.
- We will bill your insurance for a period of three (3) months after services are rendered. Any outstanding balance after the 3 month period is the responsibility of the patient.
- If for some reason your account should become delinquent, you are responsible to pay for all rebilling charges, interest charges, collection costs and attorney fees.

I have read, understand and agreed to the above Financial Policy.

Signature of Parent, Legal guardian or Responsible party Date

ORCUTT HILLS DENTAL STUDIO
APPOINTMENT POLICY

We want to thank you for choosing us as your dental health provider. Please remember that we have reserved appointments to benefit your treatment and they should be kept. Therefore, we request at least **48 hours notice** in order to reschedule yourself and other family members.

We offer 3 easy ways to confirm appointments: phone, text and/or email. It is very important that you keep your information on file up to date for this reason. Because we want to offer the best and most prompt care to all of our patients, we ask that you confirm your appointment by 48 hours before the scheduled appointment time. Our automated system will reach out to you in the above mentioned ways, making it as simple as pressing a button to let us know that you will be at the appointment. If we are unable to confirm the appointment**, it will be cancelled**, and you will need to contact our office to reschedule.

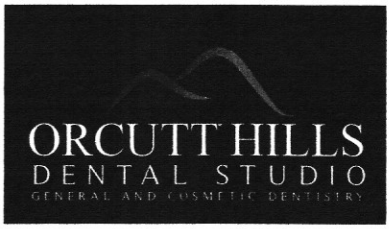
Family matters and the unexpected affect all of us. We are prepared to work with you in the event of an emergency scheduling conflict. In return, please let us know of the emergency as soon as possible. There will not be a charge as long as we receive a **48 hour notice.**

Without the appropriate notice, you will be charged a late cancellation fee of $100.00 per hour. If you are more than 15 minutes late for your appointment and we are unable to contact you, it may be considered a missed appointment. Two missed appointments may result in your dismissal as a patient.

Thank you for your consideration in this matter. Our goal is to provide outstanding dental care in a safe, comfortable environment. We appreciate the opportunity to be your dental office of choice.

_____ _____

Patient Signature Date



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
(Signature)

_____
(Date)

ACKNOWLEDGEMENT OF RECEIPT OF DENTAL MATERIALS FACTS SHEET

I, _____, acknowledge I have received from Orcutt Hills Dental Studio a copy of the Dental Materials Facts sheet dated May, 2010 as required by law.

_____
(Signature)

_____
(Date)

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

(OFFICE USE ONLY)

We attempted to obtain written acknowledgment of receipt of Privacy Practices and Dental Materials Facts Sheet, but acknowledgement could not be obtained because:

( )Individual Refused to sign ( )Communication Barriers ( ) Emergency Situation ( )Other

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14,2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorizations: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

it bonds well to both the enamel and the dentin beneath the enamel •Good for non-biting surfaces •May be used for short-term primary tooth restorations •May hold up better than glass ionomer but not as well as composite •Good resistance to leakage •Material has low incidence of producing tooth sensitivity •Usually completed in one dental visit

Disadvantages
• Cost is very similar to composite resin (which costs more than amalgam) • Limited use because it is not recommended to restore the biting surfaces of adults •Wears faster than composite and amalgam

PORCELAIN (CERAMIC)

Porcelain is a glass-like material formed into fillings or crowns using models of the prepared teeth. The material is tooth-colored and is used in inlays, veneers, crowns and fixed bridges.

Advantages
•Very little tooth needs to be removed for use as a veneer; more tooth needs to be removed for a crown because its strength is related to its bulk (size) •Good resistance to further decay if the restoration fits well •Is resistant to surface wear but can cause some wear on opposing tooth •Resists leakage because it can be shaped for a very accurate fit •The material does not cause tooth sensitivity

Disadvantages
•Material is brittle and can break under biting forces •May not be recommended for molar teeth • Higher cost because it requires at least two office visits and laboratory services

NICKEL OR COBALT- CHROME ALLOYS

Nickel or cobalt-chrome alloys are mixtures of nickel and chromium. They are a dark silver metal color and are used for crowns and fixed bridges

and most partial denture frameworks.

Advantages
•Good resistance to further decay if the restoration fits well •Excellent durability; does not fracture under stress •Does not corrode in the mouth •Minimal amount of tooth needs to be removed •Resists leakage because it can be shaped for a very accurate fit

Disadvantages
• Is not tooth colored; alloy is a dark silver metal color • Conducts heat and cold; may irritate sensitive teeth • Can be abrasive to opposing teeth • High cost; requires at least two office visits and laboratory services • Slightly higher wear to opposing teeth

PORCELAIN FUSED TO METAL

This type of porcelain is a glass-like material that is "enameled" on top of metal shells. It is tooth-colored and is used for crowns and fixed bridges

Advantages
•Good resistance to further decay if the restoration fits well •Very durable, due to metal substructure •The material does not cause tooth sensitivity •Resists leakage because it can be shaped for a very accurate fit

Disadvantages
• More tooth must be removed (than for porcelain) for the metal substructure • Higher cost because it requires at least two office visits and laboratory services

GOLD ALLOY

Gold alloy is a gold-colored mixture of gold, copper, and other metals and is used mainly for crowns and fixed bridges and some partial denture frameworks

Advantages
•Good resistance to further decay if the restoration fits well • Excellent durability; does not fracture under stress •Does not corrode in the mouth •Minimal amount of tooth needs to be removed •Wears well; does not cause excessive wear to opposing tooth •Resists leakage because it can be shaped for a very accurate fit

Disadvantages
• Is not tooth colored; alloy is yellow • Conducts heat and cold; may irritate sensitive teeth • High cost; requires at least two office visits and laboratory services

DENTAL BOARD OF CALIFORNIA
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The Facts About Fillings

DENTAL BOARD OF CALIFORNIA

Dental Materials Fact Sheet

What About the Safety of Filling Materials? Patient health and the safety of dental treatments are the primary goals of California's dental professionals and the Dental Board of California. The purpose of this fact sheet is to provide you with information concerning the risks and benefits of all the dental materials used in the restoration (filling) of teeth.

The Dental Board of California is required by law* to make this dental materials fact sheet available to every licensed dentist in the state of California. Your dentist, in turn, must provide this fact sheet to every new patient and all patients of record only once before beginning any dental filling procedure. As the patient or parent/guardian, you are strongly encouraged to discuss with your dentist the facts presented concerning the filling materials being considered for your particular treatment.

* Business and Professions Code 1648.10-1648.20

Allergic Reactions to Dental Materials Components in dental fillings may have side effects or cause allergic reactions, just like other materials we may come in contact with in our daily lives. The risks of such reactions are very low for all types of filling materials. Such reactions can be caused by specific components of the filling materials such as mercury, nickel, chromium, and/or beryllium alloys. Usually, an allergy will reveal itself as a skin rash and is easily reversed when the individual is not in contact with the material. There are no docu-