PATIENT INFORMATION

We are pleased to welcome you to our office. The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely as possible. The better we communicate, the better we can care for you. If you have any questions we will be glad to help you.

PERSONAL INFORMATION

Name_____
Last First MI (Preferred Name)

Birthdate_____ SS#_____ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Spouse's Name_____ Do you have children? [ ] Y [ ] N How Many? _____

Wireless Phone_____ Wireless Carrier_____

Home Phone_____ Work Phone_____

Email_____

Preferred contact method [ ] Home Phone [ ] Wireless Phone [ ] Text Msg [ ] Work Phone [ ] Email

Convienent day for appointment [ ] Mon [ ] Tue [ ] Wed [ ] Thu [ ] Fri [ ] Sat [ ] Sun

Convienent time for appointment [ ] 7 to 10 AM [ ] 10 to 12 PM [ ] 1 to 3 PM [ ] 3 to 6 PM [ ] 6 to 8 PM

How did you hear about us? [ ] Friend/Family [ ] Internet [ ] Yellowpages [ ] Radio [ ] TV [ ] Flyer [ ] Others

_____

(If someone referred you here, please write down their name so we can thank them. Also, if other please specify)

ADDRESS

Check box if same for entire family [ ]

Address_____

Address 2_____

City_____ State_____Zip_____

RESPONSIBLE PARTY

Person ultimately responsible for account. Disregard if same as above.

Name_____ Relation_____

Billing Address_____

City_____ State_____ Zip_____

SS#_____ Drivers Licence #_____

PRIMARY INSURANCE INOFRMATION

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____Subscriber ID # _____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

Student status if dependent over 19 (for ins) [ ] Nonstudent [ ] Fulltime [ ] Parttime

Please present insurance card to receptionist.

SECONDARY INSURANCE INFORMATION (Dual Coverage)

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____Subscriber ID # _____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

Save money by providing second insurance policy info.

EMERGENCY CONTACTS
Whom should we contact #1? _____ Relation_____
Cell Phone_____ Home Phone_____ Work Phone_____
Whom should we contact #2? _____ Relation_____
Cell Phone_____ Home Phone_____ Work Phone_____
Who is your Medical Doctor?_____
Medical Doctors Phone_____

Comments:

Name:_____

OFFICE POLICY

WELCOME TO OUR OFFICE
We are commited to providing you with the best possible care. In doing so we have set some office policies for our patients to help us achieve this goal. Thank you for your cooportation and again welcome to our practice.
FINANCIAL AGREEMENT
* For my convenience, this office may release my information to my insurance company, and receive payment directly from them. * Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible to pay. This includes any deductible amount; co-pay for insurance, or any other balances not paid by their insurance company aswell as unpaid balances due to plan exclusions/limitations, eligibility and coverage. * I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time. * We accept cash, personal checks, Visa, MasterCard, American Express, Debit Cards. Exended Payment Plans: Care Credit & Lending Club. * I agree to pay finance charges of 1.5% per month (18% APR) on any balance 30 days past due. * Treatment plans may change, and I will be responsible for the work actually done.
MISSED APPOINTMENT POLICY
Please help us serve you better by keeping your scheduled appointments. If you are not able to keep your scheduled appointment, please notify our office as soon as possible. If we do not receive notification of change or cancellation at lease 2 business days in advance, you will be billed a $50 missed appointment fee.
NOTICE OF PRIVACY POLICIES
I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities and healthcare operations. I also understand that I have the right to revoke permission.
DENTAL MATERIALS FACT SHEET
I have received the dental materials fact sheet and have had the opportuinty to read and review the contents of the sheet.

I have read the above Office Policies and Agree to the Fincial Agreement, Missed Appointment Policy, Notice of Privacy Policy, and Dental Materials Fact Sheet.

Signature_____ Date_____

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this Contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must Be Arbitrated: It is the intention and agreement of the parties that this arbitration agreement shall coverall claims or controversies relating to the matters described in Article 1 above, except claims within the jurisdiction of the Small Claims Court, whether in tort (intentional or negligent), contract, or otherwise, including but not limited to suits relating to the matters described in Article 1 and also involving claims for loss of consortium, wrongful death, discrimination, emotional distress or punitive damages. Arbitration pursuant to the terms of this Contract shall bind all parties whose claims as described in Article 1 may arise out of or in any way relate to treatment or services provided or not provided by American Family Dentistry, ("AFD") or any employee or agent or providers of AFD, including any spouse or heirs of Patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. The undersigned understands and agrees that if the undersigned signs this Contract on be half of some other person for whom the undersigned has responsibility, then, in addition to the undersigned, such person(s) will also be bound, along with anyone else who may have a claim arising out of the treatment or services rendered to that person. The reference to American Family Dentistry includes the corporation, and its employees, agents and providers. Filing any action in any court by American Family Dentistry to collect any fee from Patient shall not waive the right to compel arbitration of any claim described in Article 1. However, following the assertion of any claim against AFD, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by the same arbitration.

Article 3: Procedures and Applicable Law: Patient shall initiate arbitration by serving a Demand for Arbitration on AFD and each defendant. The claim shall be mailed by U.S. mail, postage prepaid, to: General Counsel, American Family Dentistry, 1520 Fulkerth Rd, Turlock, CA 95380. A Demand for Arbitration must be communicated in writing to all parties, identify each defendant, describe the claim against each party, and the amount of damages sought, and the names, addresses and telephone numbers of the Patient and his/her attorney. Patient and AFD agree that any arbitration here under shall be conducted by a single, neutral arbitrator selected by the parties and shall be resolved using the rules of the American Arbitration Association. (Arbitration, however, shall not be conducted by the American Arbitration Association.) Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Civil Code §§ 3333.1 and 3333.2, Code of Civil Procedure §§ 340.5, 667.7, 1281-1295 and the Federal Arbitration Act (9 U.S.C. §§ 1- 9), as in effect from time to time.

Article 4: Retroactive Effect: Patient intends this Contract to cover services rendered by AFD not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: Severability: If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Contract. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Signature_____ Date_____

Name: _____ Date:_____

In your opinion, what do you think the present state of your mouth is?

_____

_____

How healthy do you want your mouth to be?
☐ Don't Really Care ☐ Average ☐ The Best It Can Be

How long would you like your teeth to last?
☐ Dentures/Extractions ☐ Short Time ☐ Lifetime

What quality of dentistry do you want us to recommend?
☐ "Just Patch It" ☐ Average ☐ Best It Can Be

Should you need treatment, at what time would you like to start?
☐ Never ☐ Hold Off ☐ Immediately

How do you feel about the appearance of your face and smile, explain?

_____

_____

_____

Are your teeth all in alignment (straight)? ☐ Yes ☐ No
☐ Metal Braces ☐ Clear Braces ☐ 6 Month Braces ☐ Invisalign ☐ Veneers

Do you like the color of your teeth? ☐ Yes ☐ No
☐ 1 Hour Whitening ☐ Home Whitening ☐ Veneers

Do you have old and loose dentures? ☐ Yes ☐ No
☐ Denture Adhesives ☐ New Denture ☐ Implants

Do you have missing teeth affecting your chewing and bite?
☐ Yes ☐ No **If yes, explain:**

_____

<u>Do you have?</u>
Chipped Teeth ☐ Sticking Out Teeth ☐ Small Teeth ☐ Worn Out Teeth ☐ Spaces in Teeth ☐ Crowding ☐

Are there any old fillings or dental work that you don't like looking at?
☐ Yes ☐ No **If yes, explain**

_____

How would like your teeth to look?

_____

_____

_____

Last Name:_____ **First Name:**_____

Birthday:_____

Do you have any of the following diseases, medical conditions or procedures?

Cardiovascular Health	Yes	No
High blood pressure	[ ]	[ ]
Angina or heart attack	[ ]	[ ]
Chest pain on physical exertion	[ ]	[ ]
Coronary artery blockage or treatment (bypass, stent, etc.)	[ ]	[ ]
Heart valve problem or replacement	[ ]	[ ]
Heart murmur	[ ]	[ ]
Heart disease, problem or treatment	[ ]	[ ]
Rheumatic fever	[ ]	[ ]
Past use of Fen-Phen	[ ]	[ ]
Irregular heart beat or pacemaker	[ ]	[ ]
Difficulty breathing when lying down	[ ]	[ ]
Stroke	[ ]	[ ]
Low blood pressure	[ ]	[ ]

Muscular-Skeletal/CNS/Mental Health	Yes	No
Joint replacement	[ ]	[ ]
Arthritis	[ ]	[ ]
Osteoporosis	[ ]	[ ]
Fainting spells or dizziness	[ ]	[ ]
Seizures	[ ]	[ ]
Numbness or muscle weakness	[ ]	[ ]
Multiple sclerosis	[ ]	[ ]
Mental retardation	[ ]	[ ]
Dementia/Alzheimer's disease	[ ]	[ ]
Anxiety/Nervousness	[ ]	[ ]
Mental health treatment	[ ]	[ ]

Respiratory Health	Yes	No
Asthma	[ ]	[ ]
Emphysema or respiratory problems	[ ]	[ ]
Chronic sinus problems	[ ]	[ ]
Tuberculosis or persistent cough	[ ]	[ ]

Gastro-Intestinal/Genito-Urinary Health	Yes	No
Hepatitis (A, B, C or other)	[ ]	[ ]
Liver disease	[ ]	[ ]
Kidney disease/dialysis	[ ]	[ ]
Stomach trouble/ulcers	[ ]	[ ]
Sexually transmitted disease	[ ]	[ ]

Endocrine/Blood/Immune Health	Yes	No
Diabetes	[ ]	[ ]
Frequent thirst or frequent urination	[ ]	[ ]
Thyroid problems	[ ]	[ ]
Abnormal bleeding, bruise easily	[ ]	[ ]
Hemophilia	[ ]	[ ]
Anemia/blood disease	[ ]	[ ]
Cancer	[ ]	[ ]
Radiation therapy/chemotherapy	[ ]	[ ]
HIV infection/AIDS	[ ]	[ ]
Cold sores/canker sores	[ ]	[ ]
Organ transplant	[ ]	[ ]
Blood transfusion	[ ]	[ ]

Females Only	Yes	No
Are you pregnant?	[ ]	[ ]
Are you nursing now?	[ ]	[ ]
Do you take birth control pills?	[ ]	[ ]

Other diseases, medical conditions or procedures Yes [ ] No [ ]

Are you allergic to any of the following?

	Yes	No		Yes	No		Yes	No		Yes	No
Anesthetic	[ ]	[ ]	Iodine	[ ]	[ ]	Codeine	[ ]	[ ]	Penicillin	[ ]	[ ]
Aspirin	[ ]	[ ]	Latex	[ ]	[ ]	Ibuprofen	[ ]	[ ]	Sulfa	[ ]	[ ]

Other Allergies Yes [ ] No [ ]

List all medications that you are now taking?

Tobacco use? If so, what kind and how much?

Unusual reaction to dental injections?

Reason for today's visit?

Are you in pain?

New Patients:

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old?

Do you have Bitewing x-rays that are less than 1 year old?

Name of former dentist include city and state

Date of last cleaning and exam

Reason for leaving last dentist

What can be done to make your visit more comfortable?

Signature:_____ **Date:**_____

GENERAL CONSENT

1. EXAMINATIONS AND X-RAYS
I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. I understand I am to have work done as detailed in the attached treatment plan.

2. DRUGS, MEDICATION AND SEDATION
I have been informed and 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). I have informed the Dentist of any known allergies. They may cause drowsiness, lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for al least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness or oral contraceptives (birth control pills). I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. Therefore,, it is critical that I tell my dentist of all medications I am currently taking.

3. CHANGES IN TREATMENT PLAN
I understand that during treatment it may be necessary to change or 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 my permission to the Dentist to make any/all changes and additions as necessary.

4. DENTAL PROPHYLAXIS (CLEANING)
I understand the treatment is preventative in nature, intended for patients with healthy gums, and is limited to the removal of plaque and calculus from the tooth structures in the absence of periodontal (gum) disease.

5. FILLINGS
I understand that a more extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure found during preparation. This may lead to other measures necessary to restore the tooth to normal function. This may include root canal, crown, or both. I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I understand that sensitivity is a common after effect of a newly placed filling.

6. DENTAL BENEFITS
I understand that my insurance may provide only the minimum standard of care. I understand that submitting insurance and receiving a benefit is my responsibility. I elect to follow the Dentist's recommendation of optimal dental treatment.

7. REMOVAL OF TEETH
Alternatives to removal have been explained to me (root canal therapy, crown, and periodontal surgery, etc.) and I authorize the Dentist to remove 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, exposed sinuses, loss of feeling in my teeth, lips, tongue and surrounding tissue (Parasthesia) that can last for an indefinite period of time or fractured jaw. I understand bleeding could last for several hours. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contacted. I understand that 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.

8. CROWNS, BRIDGES, VENEERS AND BONDING
a. 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 that the final opportunity to make changes in my new crown, bridge, or veneer (including shape, fit, size and color) will be before cementation. It has been explained to me that, in a very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures. It is also my responsibility to return for permanent cementation within 20 days after tooth preparation. Excessive delays may allow for decay, tooth movement, gum disease, and/or bite problems. This may necessitate a remake of the crown, bridge, or veneer. I understand there will be additional charges for remakes or other treatment due to my delaying permanent cementation.

b. I am electing to use noble, high noble or ceramic instead of base metal in my crown and bridge restorations.

c. I am electing to do a fixed bridge or implant replacement of missing teeth instead of a removable appliance. I understand that this fixed bridge or implant and crown may not be a covered benefit under my insurance policy.

9. DENTURES – COMPLETE OR PARTIAL
I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be the “teeth in wax” try-in visit. Immediate dentures (placement of dentures immediately after extractions) may be uncomfortable at first. Immediate dentures may require several adjustments and relines. A permanent reline or a second set of dentures will be necessary later. This is not included in the initial denture fee. 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. I understand that it is my responsibility to return for delivery of dentures. I understand that failure to keep delivery appointments may result in poorly fitted dentures. If a remake is required due to my delay of more than 30 days, there will be additional charges.

10. ENDODONTIC TREATMENT (ROOT CANAL)
I realize there is no guarantee that root canal treatment will save my tooth, that complications can occur from the treatment, and that occasionally, canal material may extend through the root tip which does not necessarily affect the success of the treatment. The tooth may be sensitive during treatment and even remain tender for a time after treatment. Hard to detect root fracture is one of the main reasons root canals fail. Since teeth with root canals are more brittle than other teeth, a crown is necessary to strengthen and preserve the tooth. I understand that endodontic files and reamers are very fine instruments and stresses 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 in spite of all efforts to save it.

11. PERIODONTAL TREATMENT
I understand that I have a serious condition causing gum inflammation and/or bone loss, and that it can lead to the loss of my teeth and/or negative systemic conditions (including uncontrolled diabetes, heart disease, and pre-term labor, etc.). Alternative treatment plans have been explained to me, including non-surgical therapy, antibiotic/antimicrobial treatment, gum surgery, and/or extractions. I understand the success of any treatment depends in part on my efforts to brush and floss daily, receive regular therapeutic cleanings as directed, follow a healthy diet, avoid tobacco products and follow other recommendations. I understand bleeding could last for several hours. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contacted. I understand that periodontal disease may have a future adverse effect on the long-term success of dental restoration work.

12. BLEACHING
Bleaching is a procedure done either in office (approximately 1 hour) or with take-home trays (several treatments over 2-4 weeks). The degree of whitening varies with the individual. The average patient achieves considerable change (1-3 shades on the dental shade guide). Coffee, tea and tobacco will stain teeth after treatment and are to be avoided for at least 24 hours after treatment. I understand I may experience sensitivity of the teeth and/or gum inflammation, which may subside when treatment is discontinued. The Dentist may prescribe fluoride treatments to aid with sensitivity. Carbamide peroxide and other peroxide solutions used in teeth bleaching are approved by the FDA as mouth antiseptics. Their use as bleaching agents has unknown risks. Acceptance of treatment means acceptance of risk. Pregnant women are advised to consult with their physician before starting treatment.

13. NITROUS OXIDE
I elect to have nitrous oxide in conjunction with my dental treatment. I have been informed and understand the possible side effects that may occur. These include, but are not limited to, nausea, vomiting, dizziness and headache. I understand that nitrous oxide use is not indicated if I am pregnant.

14. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)
I understand that popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility.

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 I have requested and authorized. 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 corporate entity, other than the treating Dentist, is responsible for my dental treatment. I acknowledge the receipt of and understand post-operative instructions and have been given an appointment date to return.

Signature_____ Date_____