Rex E. Grizzle, D.D.S., F.A.G.D.

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THE OFFICE OF REX E. GRIZZLE, D.D.S., F.A.G.D.

We are delighted you have chosen our practice, and look forward to helping you with your dentistry for many years to come. We feel that every patient in our practice deserves to have a smile they can be proud of. We are excited to offer our patients a unique program we call **Lifetime Bleaching**.

When you come to our office for your initial examination and cleaning we will provide you with custom bleaching trays and materials for a onetime enrollment fee of $99.00. Then, at each six month preventive visit, we will give you a complimentary touch up kit of bleaching gel. This ensures that you will be able to keep your teeth bright and beautiful for life!

All we ask in return is:

- **You keep your six month preventive visits current.** Your long term dental health is as important to us as it is to you. Our patients have found that these six month visits help greatly reduce emergencies. That is why we are happy to provide this extra bonus for our patients who are committed to their dental health.
- **Provide at least 48 hours notice if you need to cancel or change an appointment.** In order to provide exceptional services like Lifetime Bleaching to all our patients, we ask that you give us the courtesy of advance notice for schedule changes.

We appreciate the opportunity to serve you, and look forward to seeing your bright smile for many years to come!

I understand the Lifetime Bleaching program requirements, and would like to enroll.

Signed_____ Date_____

*Your Lifetime Bleaching membership is valid as long as Dr. Grizzle retains his private practice in dentistry.

28914 Old Hwy. 80, Suite 104 • Pine Valley, CA 91962
Email rgrizzle@cox.net

We are complimented that you have selected us to provide dental care for you and your family.

Patient Information

Date _____ What are your hobbies and interests? _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Cell# _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Name of nearest relative not living with you _____

Complete Address _____ Phone _____

Responsible Party Information

Name _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 years) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Employer Address _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Employer Address _____

Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____

Insurance Co. Address _____ Ph. # _____

Is policy connected with your union? Yes _____ No _____ Name of Union _____ Local No. _____

Do you have dual coverage? Yes _____ No _____ if yes: **Please complete the following secondary insurance information.**

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Co. _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Ph. # _____

Insured's Employer _____ Ph. # _____

Dental Information

Do your gums bleed when you brush? Yes _____ No _____

Are your teeth sensitive to heat or cold? Yes _____ No _____ Pressure Yes _____ No _____ Sweets Yes _____ No _____

Do you grind or clench your teeth? Yes _____ No _____

Do you have any fear of dental work? Yes _____ No _____

Date of last dental examination _____ What was done at that time? _____

_____

How would you describe your current dental problem? _____

_____

How do you feel about the appearance of your teeth? _____

Please complete back page

Medical Information

1. Are you having pain or discomfort at this time? ..... YES NO
2. Have you been a patient in the hospital during the past two years? ..... YES NO
3. Have you been under the care of a medical doctor during the past two years? ..... YES NO
   Physician's Name _____ Phone No. _____
   Address _____
4. Have you taken any medication or drugs during the past two years? ..... YES NO
5. Are you now taking any medication or drugs? ..... YES NO
   If yes, please list: _____
6. Are you sensitive or allergic to any medication or anesthetics? ..... YES NO
   If yes, please list: _____
7. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure	YES	NO	Artificial Joints (hip, knee, etc.)	YES	NO	Hepatitis B (serum)	YES	NO
Heart Disease or Attack	YES	NO	Kidney Trouble	YES	NO	Venereal Disease	YES	NO
Angina Pectoris	YES	NO	Ulcers	YES	NO	A.I.D.S.	YES	NO
Congenital Heart Disease	YES	NO	Diabetes	YES	NO	H.I.V. Positive	YES	NO
Heart Murmur	YES	NO	Thyroid Problems	YES	NO	Cold Sores/Fever Blisters	YES	NO
High Blood Pressure	YES	NO	Glaucoma	YES	NO	Blood Transfusion	YES	NO
Arterioscleroses	YES	NO	Cancer	YES	NO	Hemophilia	YES	NO
Mitral Valve Prolapse	YES	NO	Emphysema	YES	NO	Anemia	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough	YES	NO	Sickle Cell Disease	YES	NO
Heart Pacemaker	YES	NO	Tuberculosis	YES	NO	Bruise Easily	YES	NO
Heart Surgery	YES	NO	Asthma	YES	NO	Liver Disease	YES	NO
Rheumatic Fever	YES	NO	Hay Fever	YES	NO	Yellow Jaundice	YES	NO
Arthritis	YES	NO	Allergies or Hives	YES	NO	Epilepsy or Seizures	YES	NO
Rheumatism	YES	NO	Sinus Trouble	YES	NO	Fainting or Dizzy Spells	YES	NO
Cortisone Medicine	YES	NO	Radiation Therapy	YES	NO	Nervousness	YES	NO
Drug Addiction	YES	NO	Chemotherapy	YES	NO	Tumors	YES	NO
Stroke	YES	NO	Hepatitis A (infectious)	YES	NO	Developmentally Disabled	YES	NO
						Fen-Fen Treatment	YES	NO

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ..... YES NO
9. Do you ever wake up from sleep and feel short of breath? ..... YES NO
10. Are you on a special diet? ..... YES NO
11. Do you have or have you had any disease, condition, or problem not listed? ..... YES NO
    If yes, please list: _____

I authorize the use of my radiographs or photographs for use in seminars or publications of this dental office.

Patient Signature _____ Date _____

FOR WOMEN ONLY:

Are you pregnant? ☐ Yes, what month? _____ ☐ No Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____

CONSENT:

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 - 1/2% finance charge (18% APR) may be added to my account.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

FOR OFFICE USE: Reviewed by Dr. _____ **Date** _____

The Office of Rex E. Grizzle, D.D.S., F.A.G.D.

In order to serve you better and give you the individual attention you deserve, please check the appropriate responses

I have a fear of – I have concerns about:

___Experiencing pain
___Not being numb
___Needles
___Unnecessary or wrong treatment
___Gagging
___Losing control
___Having something put over my mouth
___Being scolded or made to feel ashamed
___Catching a disease
___Losing my teeth
___Having to wear a denture or partial
___Other _____

The following makes me uncomfortable:

___The sounds of a dental drill
___Laying down in a dental chair
___The smells in a dental office
___Being numb
___Having to wait in the reception area
___Other_____

To understand what's going on in my mouth, my preference is:

___To know all the details
___To be given the bottom line
___To be shown pictures and movies
___To read pamphlets and brochures
___To talk with a team member about solutions to my problems

My dental experiences as an adult have been:

___Completely pain free and comfortable
___Somewhat uncomfortable
___Painful
___Traumatic
___I have not seen the dentist as an adult or my visits have been very few

When I think about coming to the dentist I feel:

___**Comfortable** - I have no anxiety about seeing the dentist or dental procedures
___**Anxious** – I don't want to come but I make myself, however I am seldom comfortable
___**Fearful** – I have stayed away from the dentist because of my fear and avoid coming unless absolutely necessary
___**Extremely Fearful** – I cannot cope with dental visits and have avoided the dentist for years to the detriment of my dental health

I have avoided the dentist because of:

___Anxiety and fear
___Budget concerns
___Time concerns
___No sense of urgency
___Lack of trust
___Other_____

My childhood dental experiences were:

___Completely pain free and comfortable
___Somewhat uncomfortable
___Painful
___Traumatic
___I did not go to the dentist as a child

My immediate concern about my teeth and my smile is: _____

_____

_____

_____

_____

_____

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Oral Screening Consent Form

Complete each time the examination is performed and place in the patient's file

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health care to our patients. We are concerned about oral cancer and look for it in every patient.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors but **more than 25% of oral cancer victims have no such lifestyle risk factors.** Oral cancer risk by patient profile is as follows:

Increased risk: *patients ages 18-39*
High risk: *patients age 40 and older; tobacco users (any age, any type within 10 years)*
Highest risk: *patients age 40 and older with lifestyle risk factors (tobacco and/or alcohol use); previous history of oral cancer*

We have recently incorporated ViziLite® Plus into our oral screening standard of care. We find that using ViziLite Plus along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. ViziLite Plus is similar to proven early detection procedures for other cancers such as mammography, Pap smear, and PSA. ViziLite Plus is a simple and painless examination that gives the best chance to find any oral abnormalities at the earliest possible stage. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. The ViziLite Plus exam will be offered to you annually.

This enhanced examination is recognized by the American Dental Association code revision committee as CDT-5 procedure code D0431; however, this exam might not be covered by your insurance. The fee for this enhanced examination is $\$65$.

Yes. I authorize the clinician to perform the ViziLite Plus exam along with the standard oral cancer examination. I accept financial responsibility for this enhanced examination.

Print name: _____

Signature: _____ Date: _____

No. I would prefer not to have the ViziLite Plus exam at this time.

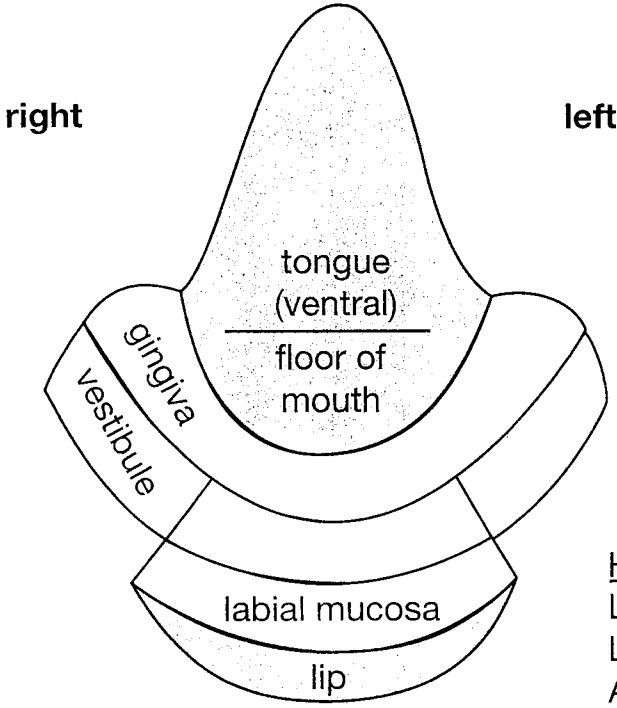
Print name: _____

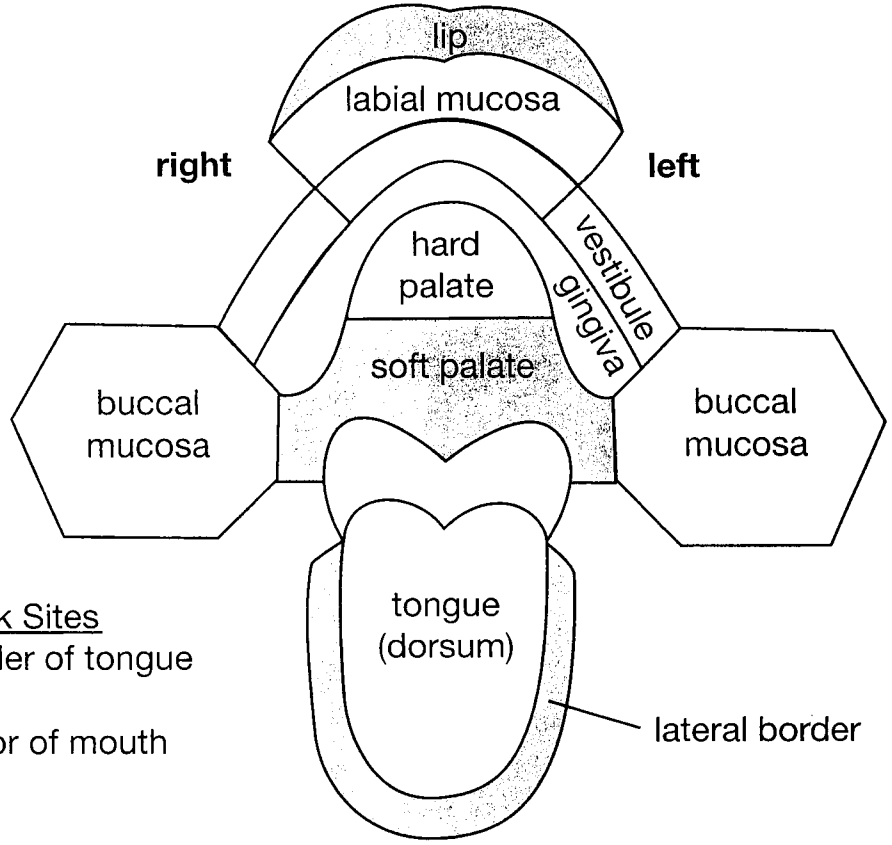
Signature: _____ Date: _____

VizíLite® Plus
ORAL LESION IDENTIFICATION AND MARKING SYSTEM
Better screening saves lives™ WITH TBLUE 630™
2% A TOLONIUM CHLORIDE

Patient _____ ID _____

Clinician _____ Date _____





Highest Risk Sites
Lateral border of tongue
Lip
Anterior floor of mouth
Soft palate