PATIENT REGISTRATION

DATE: _____

Reason for today's visit: _____

Whom may we thank for referring you? _____

PATIENT INFORMATION

Patient Name: Last: _____ First: _____ MI: _____
SS#: _____ DOB: _____/_____/_____ Sex: M / F
Phone #: Home: _____ Work: _____ Cell: _____
Address: _____ City: _____ Zip: _____
Email: _____
Status: Single / Married / Widowed / Divorced / Partnered / Separated / Minor
Patient Employer/School: _____ Occupation: _____
Employer/School Address: _____

DENTAL INSURANCE

Who is responsible for this account? _____ Relationship to patient _____
Subscribers Name: _____ D.O.B.: _____ SS#: _____
Insurance Co. Name: _____ Phone #: _____
Group#: _____ ID#: _____ Effective date: _____
Employer Name: _____ Address: _____

Is patient covered by additional/secondary insurance? Yes / No
Relationship to patient? _____
Subscribers Name: _____ D.O.B.: _____ SS#: _____
Insurance Co. Name: _____ Phone #: _____
Group#: _____ ID#: _____ Effective date: _____
Employer Name: _____ Address: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Smile Design Dental Group all insurance benefits if any, otherwise payable 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.
The above named dentist may use my health care information and may disclose such information to the above named Insurance Company('s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian or Personal Representative: _____.
Please print name of Patient, Parent, Guardian or Personal Representative: _____.
DATE: _____

P: 949.481.2000 | F: 949.481.2411
390 CAMINO DE ESTRELLA | SAN CLEMENTE, CA 92672

DENTAL EXAM, XRAYS AND CLEANING: I give permission to the dentist and his assistants as regulated by California laws and regulations to perform the initial exam, x-rays and cleaning. I have informed in writing Smile Design Dental Group employees of any and all precautions / conditions that would prevent me from having these procedures done. **INITIALS:** _____

HIPPA: I have received / been given copy of NOTICE OF PRIVACY PRACTICES to read. I consent to the use and disclosure of my personal health information by your office during Treatment, Billing/Payment and Healthcare operations as outlined in the Notice of privacy Practices. **INITIALS:** _____

CANCELATION POLICY: We respect our patient's time by seeing you on time and reserving your appointment especially for you. We ask for the same respect from you by coming to your appointments on time. I understand that a **$50 cancellation fee** will be charged for any dental appointment cancelled/rescheduled if proper notification is not received within **48 hours** prior to appointment. Patient/Responsible party must call during the office hours and speak to a live person. (Leaving a message with answering service is not valid) **INITIALS:** _____

PAYMENT POLICY: Financial arrangements must be made in advance of dental treatment. Patients with insurance coverage must pay any and all co-pays, deductibles, and not covered procedures/upgrades at the time of treatment. Smile Design Dental Group will process the necessary insurance claims and accept insurance reimbursement, but ultimately the patient is directly responsible for the reimbursement of all dental services. A service charge of **1.5% per month** on the unpaid balance will be charged on all accounts exceeding 30 days, unless prior arrangements are made. In the case of collection agency, additional **10%** will be charged to offset collection fees. In the case of returned check, a **$25 returned check fee** will be charged. **INITIALS:** _____

I permit Smile Design Dental Group to leave a message on answering machine/with my family member when I am not able to receive phone call. **INITIALS:** _____

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 at least 12 hours or until fully recovered from the effect of the anesthetic, medication and drugs that may have been given to me in the office for my care. I understand that failure to take medication prescribed for me in the manner prescribed mat offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce effectiveness of oral contraceptives.
INITIALS: _____

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. **INITIALS:** _____

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. I give my permission to the Dentist to make any/all changes and additions as necessary.
INITIALS: _____

Dental Services agreement: Performing Dentist and the Undersigned Patient have agreed as follows: It is understood that any dispute as to dental malpractice, that is as to whether any dental services rendered under this contract were unnecessary or unauthorized, were improperly, negligently or incompletely 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 provides for judicial review or arbitration proceedings, both parties to this contract by entering into it are giving up their constitutional right to have such dispute decided in a court of law, before jury, and instead are accepting the use of arbitration. In the event of any claim, demand, controversy or dispute the essential nature of which involves personal injury, malpractice or any tort, by patient, his dependents, whether or not minors, heirs at law or personal representatives against Doctor or any of Doctor's officers, directors, shareholders, agents, representatives, employees, successors, in interests, assigns or associates agreeing in writing to be bound by the arbitration provisions of this agreement. The sole method for resolving such dispute shall be binding arbitration administered by the American Arbitration Association in accordance with Commercial Arbitration Rules.
INITIALS: _____

Patient Name: PRINT: _____ **SIGNATURE:** _____ **Date:** _____
Doctors Signature: _____ **Date:** _____

SMILE DESIGN
DENTAL GROUP

HEALTH HISTORY

DENTAL HISTORY

Former Dentist_____City/State_____

Date of last dental visit_____ Date of last dental X-rays _____

Have you ever had any complications following dental Treatment? Yes / No

If yes, please explain: _____

What would you like to discuss with your dentist today?:

Bad breath(Y N)	Bleeding gums(Y N)	Blisters on lips or mouth(Y N)	Soreness on tongue(Y N)
Chew on one side of mouth(Y N)	Mouth breathing(Y N)	Tooth ache(Y N)	Cosmetic Dentistry(Y N)
Orthodontic treatment (Y N)	Pain around ear(Y N)	Grinding teeth(Y N)	Crowns/Bridges(Y N)
Sensitivity to cold(Y N)	Sensitivity to heat(Y N)	Sensitivity to sweets(Y N)	Pain when biting(Y N)
Clicking or popping jaw(Y N)	Dry mouth (Y N)	Foreign objects(Y N)	Removal of Wisdom teeth(Y N)
Dentures(partial/complete)(Y N)	Routine Check-up(Y N)	Second Opinion(Y N)	Replacement of missing teeth(Y N)
Gums swollen or tender(Y N)	Jaw pain or tiredness(Y N)	Loose teeth or broken fillings(Y N)	Growths in your mouth(Y N)

Do you smoke Cigarettes/Cigars? (Y N) Do bite on your fingernail/chew ice? (Y N)

How often do you floss? _____ How often do you brush? _____

Have you ever had problem with previous dental treatment?(Y N) Level of anxiety about seeing a dentist:: (least)1 2 3 4 5(most)

Do you normally take antibiotic prior to dental treatment? (Y N) Are you pleased with appearance of your smile? (Y N)

MEDICAL HISTORY

Physicians Name: _____

Date of last visit: _____ Phone Number: _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen? Yes No

Please circle to indicate if you have or have had any of the following:

AIDS/HIV(Y N)	Cancer(Y N)	Hepatitis(Y N) Type ____	Immunosuppressed(Y N)
Heart Murmur(Y N)	Chemotherapy(Y N)	Herpes(Y N)	Tuberculosis(Y N)
Heart Attack(Y N)	Radiation Treatment(Y N)	Cold Sores(Y N)	Glaucoma(Y N)
Heart Surgeries(Y N)	Tumor on head /neck(Y N)	Anemia(Y N)	Headaches (Y N)
Heart Bypass(Y N)	Cortisone Treatments(Y N)	Bruise Easily(Y N)	Sinus Trouble(Y N)
Artificial Heart Valves(Y N)	Blood Disease(Y N)	Skin Rash(Y N)	Fainting or dizziness(Y N)
Mitral Valve Prolapse (Y N)	Blood Transfusion(Y N)	Scarlet/Rheumatic Fever(Y N)	Epilepsy(Y N)
Congenital Heart Lesions(Y N)	Kidney Disease(Y N)	Jaundice(Y N)	Swollen Feet or Ankles(Y N)
Cardiac Pacemaker(Y N)	Liver Disease(Y N)	Lupus(Y N)	Stomach Problems(Y N)
Angina(Y N)	Venereal Disease(Y N)	Shingle/Chicken Pox (Y N)	Back Problems(Y N)
Diabetes (Y N)	Respiratory Disease(Y N)	Hay Fever(Y N)	Psychiatric Care(Y N)
Stroke(Y N)	Emphysema(Y N)	Arthritis/Rheumatism(Y N)	Nervous Problems(Y N)
Circulatory Problems(Y N)	Shortness of Breath(Y N)	Artificial Joints(Y N)	Alcohol/Drug Abuse(Y N)
High Blood Pressure(Y N)	Asthma(Y N)	Swollen Neck Glands(Y N)	
Low Blood Pressure(Y N)	Thyroid Problems(Y N)	Tonsillitis(Y N)	

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Women only: Are you pregnant?(Y N) Due date: Are you nursing? (Y N) Taking birth control?(Y N)

Do you bleed excessively with extractions/surgeries?(Y N) Do you wear contact lenses? (Y N)

Do you pre-medicate prior to dental cleanings/procedures?(Y N)

MEDICATIONS Please list any medications you are currently taking and the correlating diagnosis

_____

ALLERGIES Please circle any that you are/have been allergic to:

Aspirin	Local Anesthetic	Barbiturates (Sleeping pills)	Penicillin	Codeine	Sulfa
Iodine	Latex	Anesthetics (ie. Novacaine)	Epinephrine	Jewelry/Metals	Sedatives

IN CASE OF EMERGENCY, CONTACT: _____ Relationship _____ Phone _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

UPDATES (To be filled in at future appointments)

1) Has there been any change in your health since your last dental appointment? Y/N For what condition?_____

Are you taking any new medications? Y/N Please list your new Medications_____

Have there been any changes to your address or phone number? Y/N

New Address: _____ New Phone Number: _____

Email address: _____

Do you have new insurance? Y/N Please write down your new insurance information_____

Patient's Signature _____

Doctor's Signature _____ **Date**_____

2) Has there been any change in your health since your last dental appointment? Y/N For what condition?_____

Are you taking any new medications? Y/N Please list your new Medications_____

Have there been any changes to your address or phone number? Y/N

New Address: _____ New Phone Number: _____

Email address: _____

Do you have new insurance? Y/N Please write down your new insurance information_____

Patient's Signature _____

Doctor's Signature _____ **Date**_____

3) Has there been any change in your health since your last dental appointment? Y/N For what condition?_____

Are you taking any new medications? Y/N Please list your new Medications_____

Have there been any changes to your address or phone number? Y/N

New Address: _____ New Phone Number: _____

Email address: _____

Do you have new insurance? Y/N Please write down your new insurance information_____

Patient's Signature _____

Doctor's Signature _____ **Date**_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL 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 dental information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our dental office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share dental information about you. We also describe your rights and certain duties we have regarding the use and disclosure of dental information. Throughout this notice we refer to your medical information as dental information.

Law Requires Us to:

1. Keep your dental information private.

2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your dental information.

3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.

2. Make the changes in our privacy practices and the new terms of our notice effective for all dental information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

The following section describes different ways that we use and disclose dental information. For each kind of use or disclosure, we will explain what we mean and give an example. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose dental information. We will not use or disclose your dental information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice

FOR TREATMENT: We may use dental information about you to provide you with dental treatment or services. We may disclose dental information about you to doctors, nurses, technicians, or other people who are taking care of you. We may also share dental information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may Use and disclose your dental information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your dental information.

If you would like a copy of this form we will gladly make it for you, just ask the receptionist.

☐ Patient refused to sign

☐ Other_____

(Possible reasons: Language difficulty, communication barriers, dental emergency)

_____ _____ _____

(Printed Name) (Signature of patient) (Date)