Broken Appointment Notice

A broken appointment is a loss to everyone.
If you are unable to keep your appointment, please let us know at least 24 hours in advance so that we may schedule another patient and reschedule your appointment.
There will be a $25.00 dollar charge for each broken appointment without a 24 hours notice.

Thank you for your cooperation
Dr. Maribel A. Celebrado & Staff

Patient Signature Date

Dr. Maribel A. Celebrado
(619) 258-0355

TO OUR PATIENTS:

All insurance co-payments and deductible are due at the time of service.

It is the patient's responsibility to keep in contact with their insurance company in order to track whether their insurance deductible has been met for the year.

Patient Signature Date

Witness Date

Dr. Maribel A. Celebrado
1571 N. Magnolia Ave., Ste 205
El Cajon, Ca. 92020

Patient Acknowledgement of Receipt of Dental Material Fact Sheet

As of January 1, 2002 the Dental Board of California now requires that we distribute to our patients a copy of the Dental Materials Fact Sheet. If you would, please print and sign your name below.

I, _____, acknowledge I have received a copy of the Dental Materials Fact Sheet.

_____ _____

Patient Signature Date

Patient Name

General Dentistry Informed Consent

1. WORK TO BE DONE
I understand that I am having the following work done: Exam__, X-rays__, Prophylaxis__, Sealants__, and Other__
Initials x_____

2. DRUGS AND MEDICATION
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. **Initials x_____**

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. For example, root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary. **Initials x_____**

4. REMOVAL OF TEETH
Alternatives to removal have been explained to me (root canal therapy, and periodontal surgery) and I authorize the Dentist to remove the following teeth #_____ and any other 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, so of which are pain, swelling, spread of infection, dry socket, 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 I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility. **Initials x_____**

5. CROWN AND BRIDGE
I understand that sometimes it is not possible to match the color of natural 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 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. **Initials x_____**

6. 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 the occasionally root canal filling material may extend trough 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 in spite of all effort to save it. **Initials x_____**

7. 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 future adverse effects on my periodontal condition. **Initials x_____**

8. FILLINGS

I understand that care must be exercised in chewing on fillings especially during the first 24 hrs 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 affect of a newly placed filling. **Initials x_____**

9. DENTURES

I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate denture placement after extractions may be painful. Immediate denture 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 remake is required due to my delays of more than 30 days, there will be additional charges. **Initials x_____**

I understand that dentistry is not an exact science end, that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made be anyone regarding the dental treatment, which I have requested and authorized. 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 fees, collection fees, or court costs that may be incurred to satisfy this obligation.

X_____ Date _____
Signature of Patient/Parent or Guardian

X_____ Date _____
Signature of Dentist

X_____ Date _____
Signature of Witness

We Would Like to Get to Know You Better!

Date_____

Full Name _____ Phone (Hm) ( ) _____ - _____ (Cell) ( ) _____ - _____

Address _____ City _____ State _____ Zip _____

Email _____ Date of Birth _____ Age ____

If Child, Parent/Legal Guardian Name(s): _____

Drivers License # _____ Marital Status _____ Spouse's Name _____

Occupation _____ Employer _____ (Wk) ( ) _____ - _____ Work Hrs _____

Contact in Case of Emergency _____ Phone ( ) _____ - _____

When was your last dental appointment? _____ How did you hear about us? _____

Why did you leave your last Dentist? _____

We Want to Take Care of Your Concerns and Needs First…

What are your present dental concerns today? _____

Do you avoid brushing any part of your mouth?	( ) Yes	( ) No
Do your gums bleed when brushing?	( ) Yes	( ) No
Are your teeth sensitive to sweets, hot/cold, or biting pressure?	( ) Yes	( ) No
I want to know about longer lasting solutions that may cost more.	( ) Yes	( ) No
Are you dissatisfied with your teeth and their appearance?	( ) Yes	( ) No

Does dental treatment make you nervous?

( ) No ( ) Slightly ( ) Moderately ( ) Very

I think my dental health is…

( ) Excellent ( ) Good ( ) Fair ( ) Poor

If you could change your smile would you make your teeth…

( ) Whiter ( ) Straighter ( ) Close Spaces ( ) Repair Chips

Other concerns/needs of mine are _____

Insurance Information

Name of Subscriber _____ Subscriber's ID # _____

Subscriber's DOB_____ Employer _____

Name of Insurance Company _____ Insurance Phone ( ) _____ - _____

Group # _____ Insurance Company Address _____

Secondary Insurance:

Name of Subscriber _____ Subscriber's Social Security _____-_____-_____

Subscriber's DOB_____ Employer _____

Name of Insurance Company _____ Insurance Phone ( ) _____ - _____

Group # _____ Insurance Company Address _____

CONFIDENTIAL HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?
   If NO, explain: _____
2. Yes / No Has there been a change in your health within the last year?
   If YES, explain: _____
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain: _____
4. Yes / No Are you being treated by a physician now? If YES, explain: _____
   Date of last medical exam? _____ Reason for exam: _____
5. Yes / No Have you had problems with prior dental treatment?
   If YES, explain: _____
   Date of last dental exam: _____ Name of last treating dentist: _____
6. Yes / No Are you in pain now?
   If YES, explain: _____

II. HAVE EVER YOU EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Chest pain (angina)	Yes / No	Blood in stools	Yes / No	Frequent vomiting
Yes / No	Fainting spells	Yes / No	Diarrhea or constipation	Yes / No	Jaundice
Yes / No	Recent significant weight loss	Yes / No	Frequent urination	Yes / No	Dry mouth
Yes / No	Fever	Yes / No	Difficulty urinating	Yes / No	Excessive thirst
Yes / No	Night sweats	Yes / No	Ringing in ears	Yes / No	Difficulty swallowing
Yes / No	Persistent cough	Yes / No	Headaches	Yes / No	Swollen ankles
Yes / No	Coughing up blood	Yes / No	Dizziness	Yes / No	Joint pain or stiffness
Yes / No	Bleeding problems	Yes / No	Blurred vision	Yes / No	Shortness of breath
Yes / No	Blood in urine	Yes / No	Bruise easily	Yes / No	Sinus problems

Other: _____

III. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Heart disease	Yes / No	AIDS/HIV	Yes / No	Psychiatric care
Yes / No	Family history of heart disease	Yes / No	Surgeries	Yes / No	Osteoporosis
Yes / No	Heart attack	Yes / No	Hospitalization	Yes / No	Thyroid disease
Yes / No	Artificial joint	Yes / No	Diabetes	Yes / No	Asthma
Yes / No	Stomach problems or ulcers	Yes / No	Family history of diabetes	Yes / No	Hepatitis
Yes / No	Heart defects	Yes / No	Tumors or cancer	Yes / No	Sexual transmitted disease
Yes / No	Heart murmurs	Yes / No	Chemotherapy	Yes / No	Herpes
Yes / No	Rheumatic fever	Yes / No	Radiation	Yes / No	Canker or cold sores
Yes / No	Skin disease	Yes / No	Arthritis, rheumatism	Yes / No	Anemia
Yes / No	Hardening of arteries	Yes / No	Emphysema or other lung disease	Yes / No	Liver disease
Yes / No	High blood pressure	Yes / No	Kidney or bladder disease	Yes / No	Eye disease
Yes / No	Seizures	Yes / No	Stroke	Yes / No	Transplants
Yes / No	Cosmetic surgery	Yes / No	Eating disorders	Yes / No	Tuberculosis

Other: _____

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Aspirin	Yes / No	Valium or other sedatives	Yes / No	Codeine or other narcotics
Yes / No	Penicillin or other antibiotics	Yes / No	Latex	Yes / No	Food
Yes / No	Nitrous oxide	Yes / No	Local anesthetic	Yes / No	Metal

Others: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?
(Please circle Yes or No for each)

Yes / No	Recreational drugs	Yes / No	Tobacco in any form	Yes / No	Antibiotics
Yes / No	Over-the-counter medicines	Yes / No	Alcohol	Yes / No	Supplements
Yes / No	Weight loss medications	Yes / No	Bisphosphonate (Fosamax)	Yes / No	Aspirin
Yes / No	Anti-Depressants	Yes / No	Herbal supplements		

Please list all prescription medications: _____

VI. WOMEN ONLY (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, what month? _____

Yes / No Are you nursing?

Yes / No Are you taking birth control pills?

VII. ALL PATIENTS (Please circle Yes or No for each)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____

_____

Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: _____

Yes / No Have you ever taken Fen-Phen? If YES, when: _____

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

Whom would you like us to contact in case of an emergency?

Name:_____ **Relationship:**_____ **Phone Number:**_____

I certify 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 other 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 Dentist**	**Date**
_____	_____	_____	_____

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 INITIALS**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(AS 10/2014)

Dr. Maribel A. Celebrado
1571 N. Magnolia Ave., Ste 205
El Cajon, Ca. 92020

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

-You may refuse to sign this acknowledgement-

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

_____
Print Name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign

___ Communication barriers prohibited obtaining the acknowledgement

___ An emergency situation prevented us from obtaining the acknowledgement

___ Other (Please Specify)
_____
_____
_____