Patient Registration

ID:_____ Chart ID:_____

FIrst Name: Last Name: Middle Initial:

Patient is: _____Policy Holder Preferred Name:
_____Responsible Party (if someone other than patient)

FIrst Name: Last Name: Middle Initial:
Address:_____ Address 2:_____
City, State, Zip:_____ Pager:_____
Home Phone:_____Work Phone:_____ Ext:_____ Cellular:_____
Birth Date:_____ Soc Sec:_____ Drivers Lic:_____

____Responsible Party is also a Policyholder for Patient ____Primary Insurance Policy Holder
____Secondary Insurance Policy Holder

Patient Information
Address:_____ Address 2:_____
City, State, Zip:_____ Pager:_____
Home Phone:_____Work Phone:_____ Ext:_____ Cellular:_____
Sex: ___Male ___Female Marital Status: ___Married ___Single ___Divorced ___Separated
___ Widowed
Birth Date:_____ Soc Sec:_____ Drivers Lic:_____
Email:_____ ___I would like to receive correspondence via email

Section 2 Section 3
Employment Status: ___ Full Time ___ Part Time ___Retired Additional Comments
Student Status: ___Full Time ___ Part Time
Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref Hyg:

Primary Insurance Information
Name of Insured:_____ Relationship to Insured: ___ Self ___Spouse ___Child
___ Other
Insured Soc. Sec.:_____ Insured Birth Date:_____
Employer:_____Ins. Company:_____
Address:_____ Address 2:_____
City, State, Zip:_____
Rem. Benefits: .00 Rem. Deduct: .00

Secondary Insurance Information
Name of Insured:_____ Relationship to Insured: ___ Self ___Spouse ___Child
___Other
Insured Soc. Sec.:_____ Insured Birth Date:_____
Employer:_____Ins. Company:_____
Address:_____ Address 2:_____
City, State, Zip:_____
Rem. Benefits: .00 Rem. Deduct: .00

Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primaril;y treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.Thank you for answering the following questions.

	Yes	No	If yes:
Are you under a physician's care now?			
Have you ever had a serious head or neck injury?			
Are you taking any medications, pills, or drugs?			
Do you take, or have you taken Phen-fen or Redux?			
Have you ever taken Fosamax, Bonica, Actonel or any other medication containing bisphosphonates.			
Do you use tobacco?			
Do you use controlled substances?			
Are you on a special diet?			

Women: Are you….

___Pregnant/Trying to get pregnant? ___ Nursing? ___ Taking oral contraceptives?

Are you allergic to any of the following?

____ Aspirin ____ Penicillin ___ Codeine ___ Acrylic
____ Metal ____ Latex ___ Sulfa Drugs ___ Local Anesthetics
____ Other I f yes:_____

Do you have, or had, any of the following?

	Yes	No		Yes	No
AIDS/HIV			Congenital Heart Disorder		
Glaucoma			Leukemia		
Alzheimer's Disease			Convulsions		
Hay Fever			Liver Disease		
Anaphylaxis			Yellow Jaundice		
Heart Attack/Failure			Low Blood Pressure		
Anemia			Cortisone Medicine		
Heart Murmur			Lung Disease		
Angina			Diabetes		

Heart Pacemaker			Mitral Valve Problems		
Artificial Heart Valve			Drug Addiction		
Heart troubles/disease			Osteoporosis		
Artificial Joint			Easily Winded		
Hemophilias			Pain in Jaw Joints		
Asthma			Emphysema		
Hepatitis A			Parathyroid disease		
Blood disease			Epilepsy or seizures		
Hepatitis B or C			Psychiatric Care		
Blood transfusion			Excessive Bleeding		
Herpes			Radiation treatment		
Breathing Problems			Excessive thirst		
High blood pressure			Recent Weight Loss		
Bruise Easily			Fainting spells/dizziness		
High Cholesterol			Renal Dialysis		
Cancer			Frequent Coughing		
Hives/Rashes			Rheumatic Fever		
Chemotherapy			Frequent Diarrhea		
Hypoglycemia			Scarlet Fever		
Chest Pains			Frequent Headaches		
Irregular Heartbeat			Shingles		
Cold Sores/Fever Blisters			Genital Herpes		
Kidney Problems			Sickle Cell DIsease		
Sinus Trouble			Spina Bifida		
Stomach/Intestinal Disease			Stroke		
Swelling of Limbs			Thyroid Disease		
Tonsillitis			Tuberculosis		
Tumors or Growths			Ulcers		
Venereal Disease					

Have you ever had a serious illness not listed above?
Comments:_____
_____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in medical status.

X_____ **Date**:___

Dental Materials Fact Sheet

The following is a sample of the Dental Board of California Dental Materials Fact Sheet. The Department of Consumer Affairs has no position with respect to the language of the content of this document.

The Dental Board of California
Dental Materials Fact Sheet
Adopted on 10/17/01

As required by Chapter 801, Statutes of 1992, the Dental Board of California has prepared this fact sheet to summarize information on the most frequently used restorative dental materials. Information on this fact sheet is intended to encourage discussion between the patient and dentist regarding the selection of dental material best suited for patients dental needs. It is not intended to be a complete guide to dental materials science.

The most frequently used materia;s in restorative dentistry are amalgam, composite resin, glass ionomer cement, resin ionomer cement, ceramic porcelain, and porcelain fused to metal, gold alloys(nobel) and nickel or cobalt-chrome(base metal) alloys. Each material has its own advantages and disadvantages, benefits and risks. These and other relevant factors are compared in the attached matrix titled "Comparisons of Restorative Dental Materials". A glossary of terms is also attached to assist the reader in understanding the terms used.

The statements made are supported by relevant, credible dental research published mainly between 1993 and 2001. In some cases, where contemporary research is spare, we have indicated our best perceptions based upon information that pre-dates 1993.

The reader should be aware that the outcome of dental treatment or durability of a restoration is not solely a function of the material from which the restoration was made. The durability of any restoration is influenced by the dentist's technique when placing the restoration, the ancillary materials used in the procedure, and the patient's cooperation during the procedure. Following restoration of the teeth, the longevity of the work will be strongly influenced by patients' compliance.

Patients Name_____ Date_____

Patient Acknowledgement Form

I understand that, under the Health insurance Portability and Accountability Act of 1996 (hipaa) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. **Conduct, plan and direct my treatment and follow -up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.**
2. **Obtain payment from third party payers.**
3. **Conduct normal healthcare operations such as quality assessments and physician certifications.**

I have been informed by you or your *Notice of Privacy Practices containing* a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice Of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice Of Privacy Practices* from time to time and that I may cause this organization at any time at the address below to obtain a current copy of the *Notice Of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment payment or healthcare operations. I also understand you are not required to agree to my request restrictions, but if you agree then you are bound to abide by such restrictions.

I understand that I may revoke this acknowledgement in writing at any time except to the extent that you may have taken action relying on this acknowledgement.

Name_____ Date_____

Signiture_____

Authorized Representative_____

General Dentistry Informed Consent

Patient Name:_____

1. **Work to be done**
   I understand that I am having the following work done:
   Fillings( ), Crowns( ), Extractions( ), Impacted teeth removed( ), Root Canal Treatment( ), Dentures/Partials( ), Periodontal Treatment( ), Other( ).

_____ Initials

2. **Drugs and Medications**
   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

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 teeth that were not discovered during examination. For example, I may need root canal therapy following routine restorative procedures. The dentists will explain all changes.

_____ Initials

4. **Removal of Teeth**
   Alternatives to removal have been explained to me (root canal therapy, crowns and periodontal surgery) and I authorize the dentist to remove the following teeth _____ and any others necessary for reasons as explained in paragraph #3. I understand the risks involved in having teeth removed, some of which are pain, swelling and spread of infection,k dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (paresthesia) 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

5. **Crowns, Bridges, Onlay/Inlays, and Caps**
   I understand that sometimes it is not possible to match the color of my natural teeth. I further understand that I may be wearing temporary crowns, which may come off and that I must be careful to ensure that they are kept in until the permanent crows are delivered, I realized the final opportunity to make changed in my new crown, bridge or cap(including shape, 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 cause tooth movement. This may necessitate a remake of the crown, bridge, or cap. I understand that a root canal may be needed, even though the tooth may not have hurt prior to the crown or bridge having been done. I understand there will be additional charges for remakes due to my delaying permanent cementation

_____ Initials

6. **Root Canal Treatment**
   I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling may extend beyond the tooth which does not necessarily affect the success of the treatment =. I understand that endodontic files and reamers are very fine instruments and dresses vented in their manufactures 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

7. **Periodontal Treatment**
   I understand that I have a condition, causing gum and bone inflammation that can lead to the loss of teeth. Alternative treatment plans have been explained to me, including gum surgery, locally administered antibiotics, replacements and or extractions.

_____ Initials

8. **Fillings**
   I understand that care must be exercised in chewing on new fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling that was originally diagnosed may be required for additional decay. I understand that sensitivity is a common after effect of a newly placed filling. If the sensitivity continues, I understand that a root canal may be needed, even though the tooth may not have hurt prior to the fillings being done.

_____ Initials

9. **Dentures or Partials**
   Sore spots, altered speech, and difficulty in eating are common problems with new dentures. The ability to adapt to removable dentures varies widely. In some cases, a patient cannot or will not be able to use the device through no fault of fabrication. Immediate debenture (placement of denture immediately 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 (_____Initiaials). I understand that it is my responsibility to return for delivery of the dentures. I understand that the failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of more than 30 days, there will be an additional charge.

_____ Initials

I understand that dentistry is not an exact science and therefore, reputable practitioners cannot completely guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and authorized. I understand regardless of any dental insurance coverages I may have, I am responsible for payment of dental feeds. I agree to pay any attorney fees, collection fees, or court costs that may be incurred to satisfy the obligation.

Signature of Patient_____Date_____
Signature of Doctor_____Date_____

Golden West Dentistry Deposit Policies

Thank you so much for visiting ua and trusting us with an important aspect of your health! We look forward to getting to know you and your family.

We feel that good quality healthcare takes time. To ensure quality one on one time with the doctor, our staff has a deposit system put in place. This system is to ensure that our officer minimizes waiting times and over booking of our patients. Please feel free to ask any questions, we want to make sure we are always as transparent as possible in our operations!

Again, we want to save your time with the doctor as well as secure your appointment date and time. IN order to do this we require a non refundable deposit of $50 (per hour) for any treatment. For example, a two hour appointment would need a $100 deposit. This deposit will be due at the time you make your appointment. **This is not an additional charge!** If you come to your appointment on time then the deposit will go towards your balance. However if you are unable to make it to your appointment and do not give a 48 hour notice then you will lose your deposit and another one will be required before you reschedule the next appointment. Full payment is required on the day of your procedure and any other payment arrangements need to be approved by the manager.

(Please note that “no-show” appointments and cancellations with less than 48 hours notice will require another deposit to secure a make-up date.)

Sign:_____ Date:_____

By signing above, I understand the appointment deposit system, and that it is to reserve time with the office as well as, one on one time with the doctor. I also understand that the deposit is not an additional charge and if the appointment is completed the deposit will go towards my balance. I understand that if I do not show up to my appointment, I will lose my deposit and will need another deposit before making/rescheduling another appointment.