Patient Information Form

Today's Date

Patient Name: First_____ MI____ Last_____ Nickname_____

Address: Street_____ City_____ State_____ Zip_____

Phone: Mobile_____ Work_____ Home_____

E-mail Address _____

By Providing your e-mail address you agree to receive *(check one or both)* ☐ Appointment Reminders ☐ Practice Newsletter

What is your preferred method of contact? ☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ E-Mail

Social Security Number_____ **Date of Birth**_____

Driver's License #_____ **State Issued**_____

Patient Employed By_____ **Occupation**_____ **Phone**_____

Address: Street_____ City_____ State_____ Zip_____

Sex ☐ Male ☐ Female **Marital Status** ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

In case of emergency, who should be notified? _____

Relationship to Patient_____ **Mobile Phone**_____ **Home Phone**_____

Is the patient a Minor? ☐ Yes ☐ No **Full-time Student** ☐ Yes ☐ No **Name of School** _____

Name of Responsible Party: First_____ Last_____

Date of Birth_____ **Relationship to Patient** ☐ Self ☐ Spouse ☐ Parent ☐ Other

If patient is a Minor, primary residency ☐ Both Parents ☐ Mom ☐ Dad ☐ Step Parent ☐ Shared Custody ☐ Guardian

Address: *(if different from patient)* Street_____ City_____ State_____ Zip_____

Phone: Mobile_____ Work_____ Home_____

Employer *(if different from above)*_____ **Occupation**_____ **Phone**_____

Address: Street_____ City_____ State_____ Zip_____

Dental Benefit Plan Information

Primary Dental Plan Name_____ **Phone**_____

Address: Street_____ City_____ State_____ Zip_____

Name of Insured_____ **Date of Birth**_____ **ID/SS#**_____

Policy Number_____ **Patient Relationship to Insured**_____

Secondary Dental Plan Name_____ **Phone**_____

Address: Street_____ City_____ State_____ Zip_____

Name of Insured_____ **Date of Birth**_____ **ID/SS#**_____

Policy Number_____ **Patient Relationship to Insured**_____

DENTAL HISTORY

Name_____ Nickname_____ Age_____
Referred by_____How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor
Previous Dentist _____How long have you been a patient?_____Months/Years _____
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ ☐ ☐
2. Have you had an unfavorable dental experience? _____ ☐ ☐
3. Have you ever had complications from past dental treatment? _____ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ ☐ ☐
6. Have you had any teeth removed or missing teeth that never developed? _____ ☐ ☐

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? _____ ☐ ☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ☐ ☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? _ _____ ☐ ☐
10. Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐
11. Have you ever experienced gum recession? _____ ☐ ☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ☐ ☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____ ☐ ☐

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? _____ ☐ ☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ ☐ ☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ ☐ ☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ ☐ ☐
18. Do you have grooves or notches on your teeth near the gum line? _____ ☐ ☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ ☐ ☐
20. Do you frequently get food caught between any teeth? _____ ☐ ☐

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____ ☐ ☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ ☐ ☐
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ☐ ☐
25. Are your teeth becoming more crooked, crowded, or overlapped? _____ ☐ ☐
26. Are your teeth developing spaces or becoming more loose? _____ ☐ ☐
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? _____ ☐ ☐
28. Do you place your tongue between your teeth or close your teeth against your tongue? _____ ☐ ☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ☐ ☐
30. Do you clench your teeth in the daytime or make them sore? _____ ☐ ☐
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? _____ ☐ ☐
32. Do you wear or have you ever worn a bite appliance? _____ ☐ ☐

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change? _____ ☐ ☐
34. Have you ever whitened (bleached) your teeth? _____ ☐ ☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ☐ ☐
36. Have you been disappointed with the appearance of previous dental work? _____ ☐ ☐

Patient's Signature _____ Date _____
Doctor's Signature _____ Date _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐Excellent ☐Good ☐Fair ☐Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury_____	☐	☐
2. an allergic reaction to _____	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ other _____		
3. heart problems, or cardiac stent within the last six months __	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic implant (joint replacement) _____	☐	☐
8. rheumatic or scarlet fever_____	☐	☐
9. high or low blood pressure_____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. tuberculosis, measles, chicken pox_____	☐	☐
15. asthma_____	☐	☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency_____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c =_____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive disorders (i.e. celiac disease, gastric reflux) _____	☐	☐
26. osteoporosis/osteopenia (i.e. taking bisphosphonates)_____	☐	☐

	YES	NO
27. arthritis _____	☐	☐
28. autoimmune disease _____	☐	☐
(i.e. rheumatoid arthritis, lupus, scleroderma)		
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth_____	☐	☐
36. hives, skin rash, hay fever_____	☐	☐
37. STI / STD / HPV _____	☐	☐
38. hepatitis (type ___) _____	☐	☐
39. HIV / AIDS _____	☐	☐
40. tumor, abnormal growth_____	☐	☐
41. radiation therapy_____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. emotional difficulties_____	☐	☐
44. psychiatric treatment_____	☐	☐
45. antidepressant medication _____	☐	☐
46. alcohol / recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours		
(i.e. fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches_____	☐	☐
53. a smoker, smoked previously or use smokeless tobacco _	☐	☐
54. considered a touchy / sensitive person _____	☐	☐
55. often unhappy or depressed_____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. prostate disorders _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment.
(i.e. Botox, Collagen Injections)

_____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ (1-6)

fountains Dental Excellence

Auburn Dental Aesthetics

Financial/Office Guidelines

Accepted Forms of Payment: We will provide you with a treatment estimate in advance so that you may come prepared to pay your estimated patient portion on the same day services are rendered. For your convenience we accept Cash, Check, Visa, MasterCard, American Express, and Discover. We also offer an extended payment plan through Chase Health Advantage for patients who qualify. (Please note: A $25 NSF fee will be charged for all returned checks.)

Initial_____

Dental Insurance: Please familiarize yourself with your insurance plan and provisions and provide us with accurate and up-to-date information as necessary. As a courtesy, we will submit claims to your dental insurance company on your behalf. We will accept payments directly from your insurance company provided payment is received from them within 60 days. If payment has not been received within 60 days, we may ask that you provide assistance in dealing with your insurance company. Please remember that your benefits are a contract between you, (possibly your employer) and your insurance company; therefore, you are ultimately responsible for the total amount of your dental fees. Further, your dentist makes treatment recommendations regardless of your dental benefits, deductibles, limitations, or maximums.

Initial_____

Past Due Balance: Estimated patient portions are due the same day services are rendered. Once your insurance company has paid, there may be an additional remaining balance and it will be billed to you. We ask that you pay any remaining amount promptly. Outstanding accounts over 90 days will be assessed a monthly late fee of 1.75% of the amount due (21% per year). If financial arrangements have not been established and your account is delinquent, we reserve the right to turn your account over to a collection agency. In the event of default, I understand I am responsible for any attorney fees and court costs associated with collecting.

Initial_____

Cancellation: If you are unable to keep an appointment specifically reserved for you, we request that you notify the office at least 48 hours in advance that we may have sufficient time to fill the appointment with another patient. A fee of $50 may be assessed to your account for "no-shows" and/or appointments cancelled without advanced notice.

Initial_____

In order to customize any conversation regarding proposed dental treatment, please choose the following best suits your needs:

__ **Tell Me Everything:** Provide me with information about my entire dental health condition and inform me of all options available.

__ **Insurance Only:** I only wish to hear about treatment that may be covered under my calendar year maximum. I understand my insurance will likely have a co-payment which I am responsible for. Further, I understand there may be medical/dental health risks involved should I choose to address only those things covered by my insurance.

__ **Minimal Cost:** Focus only minimizing all costs and inform me of only the highest priority in treatment. I understand there may be medical/Dental health risks involved should on only choose

My signature verifies that I understand the policies as outlined above, and any questions I have with regard to these office policies have been answered.

Patient Signature: _____ Today's Date:_____

Notice of Privacy Practices

All information that is obtained from you by this office is protected and kept confidential. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced.

Uses and Disclosures:

- Your protected health information if accessed and used for healthcare related purposes only.
- Your protected health information is never sold, rented, transferred, exchanged, and/or used for non-healthcare related purposes including marketing activities without your written authorization.
- Your protected health information is disclosed to third-party entities without your written authorization for the purpose of treatment, to obtain payment for treatment, and for healthcare operations.

Certain Circumstances:

Your protected health information can be disclosed without your written authorization in certain limited circumstances,

- Medical emergencies
- In situations required by law
- Individuals involved in your care
- When requested by public health agency
- When requested by a law enforcement agency

For any purpose other than treatment, obtaining payment, healthcare operations, or certain circumstances, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose protected health information, you can revoke that authorization in writing at any time.

Patient Rights*:

- You have the right to request in writing to inspect and/or receive a copy of your health information.
- You have the right to request an alternate means or location to receive communications regarding your health information.
- You have the right to request in writing to amend, correct, or delete any recorded health information within our possession.
- You have the right to request in writing to restrict some of the uses and disclosures of your health information.
- You have the right to request in writing an accounting of certain disclosures of your health information that were made by this office.

Changes To This Notice: We reserve the right to change privacy practices and the conditions of this notice at any time and without prior notice. In the event of, an updated notice will be posted and a copy will be made available to you. For the safety and security of our patients and employees of Fountains Dental Excellence and Auburn Dental Aesthetics certain areas of this facility may be under video surveillance and may be temporarily recorded. Surveillance camera placement has been made with sensitivity to a patient's right to personal privacy.

**Conditions and limitations may apply; obtain additional information from front desk.*

Dental Materials Fact Sheet

What About the Safety of Filling Materials?

Patient health and the safety of dental treatments are the primary goals of California's dental professionals and the Dental Board of California. The purpose of this fact sheet is to provide you with information concerning the risks and benefits of all the dental materials used in the restoration (filling) of teeth.

The Dental Board of California is required by law* to make this dental materials fact sheet available to every licensed dentist in the state of California. Your dentist, in turn, must provide this fact sheet to every new patient and all patients of record only once before beginning any dental filling procedure.

As the patient or parent/guardian, you are strongly encouraged to discuss with your dentist the facts presented concerning the filling materials being considered for your particular treatment.

** Business and Professions Code 1648.10-1648.20*

Allergic Reactions to Dental Materials

Components in dental fillings may have side effects or cause allergic reactions, just like other materials we may come in contact with in our daily lives. The risks of such reactions are very low for all types of filling materials. Such reactions can be caused by specific components of the filling materials such as mercury, nickel, chromium, and/or beryllium alloys. Usually, an allergy will reveal itself as a skin rash and is easily reversed when the individual is not in contact with the material.

There are no documented cases of allergic reactions to composite resin, glass ionomer, resin ionomer, or porcelain. However, there have been rare allergic responses reported with dental amalgam, porcelain fused to metal, gold alloys, and nickel or cobalt-chrome alloys.

If you suffer from allergies, discuss these potential problems with your dentist before a filling material is chosen.

PORCELAIN (CERAMIC)

Porcelain is a glass-like material formed into fillings or crowns using models of the prepared teeth. The material is tooth-colored and is used in inlays, veneers, crowns and fixed bridges.

Advantages

- Very little tooth needs to be removed for use as a veneer; more tooth needs to be removed for a crown because its strength is related to its bulk (size)
- Good resistance to further decay if the restoration fits well
- Is resistant to surface wear but can cause some wear on opposing teeth
- Resists leakage because it can be shaped for a very accurate fit
- The material does not cause tooth sensitivity

Disadvantages

- Material is brittle and can break under biting forces
- May not be recommended for molar teeth
- Higher cost because it requires at least two office visits and laboratory services

NICKEL OR COBALT-CHROME ALLOYS

Nickel or cobalt-chrome alloys are mixtures of nickel and chromium. They are a dark silver metal color and are used for crowns and fixed bridges and most partial denture frameworks.

Advantages

- Good resistance to further decay if the restoration fits well
- Excellent durability; does not fracture under stress
- Does not corrode in the mouth
- Minimal amount of tooth needs to be removed
- Resists leakage because it can be shaped for a very accurate fit

Disadvantages

- Is not tooth colored; alloy is a dark silver metal color
- Conducts heat and cold; may irritate sensitive teeth
- Can be abrasive to opposing teeth
- High cost; requires at least two office visits and laboratory services
- Slightly higher wear to opposing teeth

fountains Dental Excellence

Auburn Dental Aesthetics

Acknowledgment of Receipt of Privacy Practices Notice and Dental Material Fact Sheet

This document acknowledges that you have received a copy of: Dental Material Fact Sheet.

This document is not a contract, authorization, release, or consent form. This document will remain in your records.

☐ From time to time we apprise our clients of events that may be of interest to them via email or mail. Please check here if you do **NOT** wish to be notified of such events.

I, _____, acknowledge that I have reviewed a copy of the

Notice of Privacy Practices and the Dental Material Fact Sheet.

Patient's Signature: _____ Date: _____

If the patient is a minor, a parent or legal guardian must sign.

Parent or Legal Guardian:_____ Date: _____

HIPAA PRIVACY FORM

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You may refuse to sign this acknowledgement****

I, _____, have received a copy OR read the explanation of this office's Notice of Privacy Practices.

_____
{Signature of Patient and/or Guardian} {Date}_____

(Relationship to Patient} Self or Other: _____

I, _____, acknowledge and allow Fountains Dental Excellence to share my information with the following people besides those already stated within the Notice of Privacy Practices.

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] No information is to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

The best time to reach me personally is (day) _____ between (time) _____

Please call [ ] my home phone [ ] my work number [ ] my cell number

_____ _____ _____

If unable to reach me:

[ ] you may leave a detailed message [ ] please leave me a message asking for a return call OR

You have my permission to contact me via e-mail and text messaging: Y_____ N_____

[ ] you may e-mail me at: _____

Signed: _____ Date: ____/____/_____

Witness: _____ Date: ____/____/_____