WELCOME

1950 Sunnycrest Dr. Suite 1100 Fullerton, CA 92835

1 PATIENT

Today's Date: ________________

Name: ______________________________ (Last) ______________________________ (First) Phone: ( ) ________________ Cell: ( ) ________________

Address: ______________________________ Apt: ________ City: ____________________ Zip: ____________

How long in this address: ____________________ E-mail: ______________________________

Social Security #: ____________________ DL# ____________________ Age: ________ Birthdate: ____________________

2 GETTING TO KNOW YOU

Are there other members of your household who are not patients at our office? ❑Yes ❑No
Please list names & Relationship (son, daughter, husband) below:

1. ______________________________ 2. ______________________________

3. ______________________________ 4. ______________________________

How did you hear of us? ______________________________

Are you or anyone else in your family a Union Member? ❑Yes ❑No

If yes, specify Union/Local: ______________________________

I want information in Spanish: ❑Yes ❑No

3 EMPLOYMENT

Occupation: ____________________ Employer: ____________________

How Long: ____________________ Phone: ( ) ____________________ Ext: ____________

Business address: ______________________________ City: ____________________ Zip: ____________

Verified By: ______________________________ **Date:** ____________

1. I hereby certify that information I have given is accurate and will be relied upon for granting credit and providing dental service. I understand that I am financially responsible for the charges not covered by or paid for by my insurance for whatever reason.

2. By signing below, I understand that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies.

3. I hereby authorize payment directly to the dentist of the group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims.

4. I understand that OC Smile provides business support services to independent dentist and recognize that this dental practice is operated by an independent dentist. I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist nor OC Smile is responsible for my dental treatment.

____
Signature of responsible party or patient (Parent if patient is a minor) Date

OCSmile
THE NEW STANDARD IN DENTAL CARE

MEDICAL HISTORY

1. Are you under a doctor's care at this time? ❑Yes ❑No
   If yes, please specify: Dr. Name: ______________________ Dr. Ph # ______________________

2. Are you allergic to penicillin, codeine, local anesthetics, tranquilizers or any other drugs or medicine? ❑Yes ❑No
____

3. Are you taking any medications at this time, including birth control? ❑Yes ❑No
   If yes, please specify: ____

4. (Women) are you pregnant at this time? ❑Yes ❑No If yes please specify how many months: ______________________

5. Are there any other health problems of which we should be advised? ❑Yes ❑No
   Please specify: ____

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

	Please Check Yes or No	Doctor Comments
ARTIFICIAL Heart Valve	❑Yes ❑No	______
AIDS/HIV	❑Yes ❑No	______
ANEMIA	❑Yes ❑No	______
ANGINA	❑Yes ❑No	______
ARTHRITIS	❑Yes ❑No	______
ASTHMA	❑Yes ❑No	______
BLEEDING PROBLEMS	❑Yes ❑No	______
CANCER	❑Yes ❑No	______
CHEMO/RAD THERAPY	❑Yes ❑No	______
COSMETIC SURGERY	❑Yes ❑No	______
DIABETES	❑Yes ❑No	______
DIZZY SPELLS	❑Yes ❑No	______
DRUG ADDICTION	❑Yes ❑No	______
EMPHYSEMA	❑Yes ❑No	______
EPILEPSY	❑Yes ❑No	______
FAINTING	❑Yes ❑No	______
GLAUCOMA	❑Yes ❑No	______
HEART ATTACK	❑Yes ❑No	______
HEART SURGERY	❑Yes ❑No	______
HEART MURMUR	❑Yes ❑No	______
HEART PROBLEMS	❑Yes ❑No	______

	Please Check Yes or No	Doctor Comments
HEPATITIS	❑Yes ❑No	______
HIGH BL. PRESSURE	❑Yes ❑No	______
JAUNDICE	❑Yes ❑No	______
JOINT PROSTHESIS	❑Yes ❑No	______
KIDNEY DISEASE	❑Yes ❑No	______
LATEX ALLERGY	❑Yes ❑No	______
LIVER PROBLEMS	❑Yes ❑No	______
LOW BL. PRESSURE	❑Yes ❑No	______
LUNG DISEASE	❑Yes ❑No	______
PACEMAKER	❑Yes ❑No	______
PHEN-FEN	❑Yes ❑No	______
PSYCHIATRIC CARE	❑Yes ❑No	______
RHEUMATIC FEVER	❑Yes ❑No	______
SINUS TROUBLE	❑Yes ❑No	______
SMOKING TOBACCO	❑Yes ❑No	______
STROKE	❑Yes ❑No	______
THYROID PROBLEMS	❑Yes ❑No	______
TMD OR TMJ	❑Yes ❑No	______
TUBERCULOSIS	❑Yes ❑No	______
VENEREAL DISEASE	❑Yes ❑No	______

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. I further certify that I consent to the performing of x-rays and oral examination.

____
Signature of responsible party or patient (Parent if patient is a minor) Date

____
Doctor Signature Date

RECALL REVIEW:

______________________ ______________________
Signature of responsible party or patient (Parent if patient is a minor) Doctor Signature Date

______________________ ______________________
Signature of responsible party or patient (Parent if patient is a minor) Doctor Signature Date

INFORMED CONSENT

1. **Examinations and X-rays:** I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan.

(initials__________)

2. **Drugs, Medications, And Sedation:** I have been informed and understand that antibiotics and other medications can cause allergic reaction causing redness and swelling of tissues, pain, itching, vomiting, and or anaphylactic shock (severe allergic reaction) They may cause drowsiness and 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 effects of the anesthetic, medication and drugs that may have been given me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

(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 the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

(initials__________)

4. **Temporomandibular Joint Dysfunction (TMD):** I understand that symptoms of 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, and the cost of which is my responsibility.

(initials__________)

5. **Fillings:** I understand that care must be exercised in chewing on filling during the first 24 hours to avoid breakage. I understand that sensitivity is a common after effect of newly placed filling.

(initials__________)

6. **Removal Of Teeth:** Alternatives to removal have been explained to me (root canal therapy, crowns and peridontal surgery, ect.) and I authorize the Dentist to remove the following teeth and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and may be necessary to have further treatment. I understand the risk involved in having teeth removed, some 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 or even hospitalization if complications arise during or following treatment, the cost of which is my responsiblity.

(initials__________)

7. **Crowns, Bridges, Caps, Veneers and Bonding:** I understand that sometimes it is not possible to match the color of natural teeth 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 that the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation. It has been explained to me that , in a very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may effect tooth surfaces and may require modification of daily cleaning procedures.

(initials__________)

8. **Dentures Complete Or Partial:** I realize that full or partial dentures are artificial, constructed of plastic, metal, and or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be the “teeth in wax” try in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

(initials__________)

9. **Endodontic Treatment (Root Canal):** I realize there is no guarantee that root canal treatment will save may tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoetomy.)

(initials__________)

10. **Periodontal Treatment (Scaling and Root Planing) / Prophylaxis:** I understand that I have a serious condition causing gum inflammation and or bone loss, and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery, and or extractions. I understand the success of any treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, follow a healthy diet, avoid tobacco products and follow other recommendations.

(initials__________)

I understand that dentistry is not an exact science and that therefore reputable Practitioners cannot properly 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 that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that each Dentist is an individual practitioner and is individually responsible for the Dental care rendered to me. I also understand that no other Dentist other than the treating Dentist nor OC Smile, is responsible for my dental treatment. I acknowledge the receipt of the understand postoperative instruction and have been given an appointment date to return. I have received the Dental Materials Fact Sheet.

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Signature of responsible party or patient (Parent if patient is a minor) Date

____

Doctor Signature Witness