HEALTH HISTORY

Condition	Yes	No
AIDS / HIV Positive	☐ Yes	☐ No
Anemia or Bleeding disorder	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No
Year _______		
Asthma	☐ Yes	☐ No
Autism	☐ Yes	☐ No
ADHD	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Year _______		
Chemical Dependency	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No
Year _______		
Circulatory Problems	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Epilepsy / Fainting	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Type _______		
Herpes	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Jaw Pain	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Nervous Problems	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Psychiatric Care	☐ Yes	☐ No
Radiation Treatment	☐ Yes	☐ No
Date _______		
Respiratory Disease	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Scarlet Fever	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No
Skin Rash	☐ Yes	☐ No
Special Diet	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Swelling of Feet	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No
Tonsillitis	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Tumor or growth on head or neck	☐ Yes	☐ No
Ulcer	☐ Yes	☐ No
Venereal Disease	☐ Yes	☐ No
Weight Loss, unexplained	☐ Yes	☐ No
Women:		
Are you pregnant?	☐ Yes	☐ No
Due date_______		
Are you nursing?	☐ Yes	☐ No

Other: ______________________________

Surgeries: ______________________________

Physician's Name: ______________________ Date of last visit: ______________

Pharmacy Name: ______________________ **Address:** ______________________

Doctor's Comments: ______________________________

MEDICATIONS

List medications you are currently taking:

____

____

Have you ever taken Bisphosphonates (Fosamax®, Reclast, Boniva, Actonel) ☐ Yes ☐ No

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (Sleeping pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Metal Allergy
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other ______________

DATE	PATIENT'S/PARENT'S SIGNATURE	P/BP	DOCTOR'S SIGNATURE

UPDATES (to be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? ______________________________

Are you taking any new medications? ____________ If so, what ______________________

Patient's Signature ______________________ Date: ____________

Doctor's Signature ______________________ Date: ____________

Has there been any changes in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? ______________________________

Are you taking any new medications? ____________ If so, what ______________________

Patient's Signature ______________________ Date: ____________

Doctor's Signature ______________________ Date: ____________

Patient Information

Date:________ Name ____
First Last Gender

Birthdate _____/_____/_____ If patient is a minor, give parent's/guardian's name ______________

Address____
Street City State Zip

Cell Phone (___)_____________ Home Phone (___)_____________ Social Security______________

Occupation ____________________ Drivers License #____________ Email ______________

Name of nearest relative not living with you _______________ Cell Phone (___) ___________ Relationship __________

Emergency Contact ____ Phone (___) ________

Address of emergency contact ____

Whom may we thank for referring you to our office? _______________________________

Responsible Party Information

Name____
Last First Middle Marital Status

Residence____
Street City State Zip

Mailing Address____
Street City State Zip

How long at this address___________ Home Phone (___) ___________ Work Phone (___) ___________

Previous address (if less than 3 years)___________________________________
Street City State Zip

Social Security #___________________ Birthdate ___________ Relationship to Patient ___________

Employer_____________________ Occupation_____________________ No. Years Employed________

Employer Address____

Social Security #________________ Birthdate ________________ Work Phone ______________

Insurance Information

Insured's Name ______________________________ Insured's Soc. Sec. # ________________

Insurance Company ____________________________ Group No.________________

Insurance Co. Address __________________________ Ph # ________________

Is policy connected with your union? Yes_____ No______ Name of Union ____________ Local No. __________

Do you have dual coverage? Yes______ No______ If yes: Please complete the following secondary insurance information.

Insured's Name ______________________________ Insured's Soc. Sec. # ________________

Insurance Co. ______________________________Group No.____________ Local No.__________

Insurance Co. Address __________________________ Ph # ________________

Insured's Employer ____________________________ Ph # ________________

Oral Information

Do your gums bleed when you brush? Yes____ No____

Are your teeth sensitive to heat or cold? Yes____ No____ Pressure Yes____ No____ Sweets Yes____ No____

Do you grind or clench your teeth? Yes____ No____

Do you have any fear of dental work? Yes____ No____

Date of last dental examination_________________ What was done at that time?______________________

____

Main concerm or current dental problem?_________________________________

____

What changes to the apparance of your teeth would you like to make?________________________

____

DENTAL TREATMENT CONSENT FORM

☐ 1. **WORK TO BE DONE**

I understand that I am having the following work done: Fillings________ Bridges__________ Crowns________ Extractions________
Prophylaxis__________ Sealants__________ Root Canals__________ Exam + X-Rays____________________ (Initials____________)

☐ 2. **DRUGS AND MEDICATIONS**

I 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). (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. **REMOVAL OF TEETH**

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) 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 it may be necessary to have further treatment. I understand the risks 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 (Paresthesia) that can last for an indefinite period of time (days or months) 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 responsibility. (Initials____________)

☐ 5. **CROWN, BRIDGES AND CAPS**

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 the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation. (Initials____________)

☐ 6. **DENTURES, COMPLETE OR PARTIAL**

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (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____________)

☐ 7. **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 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 (apicoectomy). (Initials____________)

☐ 8. **PERIODONTAL LOSS (TISSUE & 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 a future adverse effect on my periodontal condition. (Initials____________)

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully 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 have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient____ Date____________________

Signature of Parent/Guardian if patient is a minor______________________________ Date____________________

Office Policy

Dear Patients,

Welcome to our office. We will do our best to make your visit as comfortable as possible. We are pleased that you have chosen our office for your dental health care needs. We strive to provide our patients with high quality comprehensive dental care at a reasonable fee.

On your first visit expect: A thorough examination and review of your oral health including necessary x-rays. Teeth cleanings are schedule on a different day.

Your recommended treatment will be explained and you will receive an estimate of your cost according to your particular insurance plan. Treatment rendered and not paid by your insurance company, will be your responsibility to pay.

Please help us to serve all our patients by keeping your appointment. Every time an appointment is made a certain amount of time is reserved special just for you. If you cancel with less than 48-hours notice, we do not have the opportunity to offer your appointment to another patient in need. There will be a charge of $50 fee, per hour set aside for you, if the appropriate amount of notice is not given.

We require a deposit be made on all future treatment appointments.

We accept cash, check, debit card, Visa, MasterCard, and Internet Free Financing (information available at front desk). We offer variety of payment options, such as, 5% prepayment courtesy and In Office Plan (ask for details). Should financial arrangement be necessary, they must be made *prior* to dental treatment. Payment is due as dental treatment is rendered, unless *prior* financial arrangements have been approved. Returned checks (non sufficient funds, stop payment, etc.) will be subject to a fee of $35 in addition to the amount of the check written and will be due immediately. There is a $15 late fee for any balance past due 30 days or more. It will be charged monthly until balance due is paid in full. If our office is unable to collect any balance due within 90 days your account will be sent to collections. A $100.00 collection fee will be added to the balance due and it will be listed as a collection amount with the consumer credit reporting bureaus. If balance due is still not paid in full further action will be taken.

X-rays will be released upon signed authorization and a $35.00 duplication fee (per patient) will be charged. We are required by law to have a copy of x-rays in the chart.

____ Please be advised that for patients 18 and under cleaning, fluoride and sealants will be done same day as exam and x-ray .

I have read and understand the above policy and agree to its terms.

Signature______________________ Date______________

Dear Patient:

Due to policy provisions in your contract with your insurance carrier, we are obligated to collect all patient responsibility balances.

If your insurance policy has provisions such as deductibles, co-insurances, or co-payments please note that these are provisions that have been agreed to between you and your carrier. We cannot legally discount fees after their submission on your behalf to your carrier.
If we are networked with your carrier, we have an additional contractual obligation to collect the balances as outlined by your carrier. Writing off patient responsibility balances could jeopardize our contract with your carrier.

If a portion of your fees are applied to an annual out of pocket maximum, and we do not collect that fee, your out of pocket maximum has not been correctly calculated.
Your estimated patient portion (co-pay) is due on the day of your dental services. Your estimated portion is based on information given to us by your insurance carrier. However, we may need to send you a statement if the estimated differs from the actual insurance payment.

Additionally, for those Medicare patients that may have any medical services that are eligible under Medicare, we are legally obligated to collect the patient responsibility co-insurance, co-payment or deductible under the terms of the anti-kickback laws.

Because Insurance policies vary, we can only estimate your dental coverage due to complexities of insurance contracts. Ours fees generally, but not necessarily, fall within the usual and customary fee structure determined by your dental carrier. Not all dental services are covered by all dental plans. We will bill your insurance company and allow them 60 days to render payment. After 60 days, you will be responsible for the entire balance.

Patients Signature_______________________ Date________________

Copper Canyon Smiles
23771 Washington Ave Suit H-102
Murrieta, Ca 92561
www.coppercanyonsmiles.com

For office communication purposes we kindly request that you fill out the Information requested below. Your information will be confidential and will be only used for confirmation and communication purposes between our office and you.

Patient Name:_______________________________

Cell Phone Number: ________________________

Email Address: ____________________________________

Photography Release

I, ______________________________

Hereby authorize Dr. Rania Georgei or Dental Assistants to take photographs, Slides, and/ or videos of my face, jaws, mouth, and teeth.

I understand that the photographs, slides and or videos will be used as a record of my care, and may be used for educational purposes in study club meeting, lectures, seminars demonstrations, and professional publications (journals, magazines, and website).

I further understand that if the photography, slides, and/ or videos are used in any publication or as a part of a demonstration, my name and other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs.

______________________________ ______________________________

Print Name of Patient Patient/ Guardian Signature

PATIENT CODE OF CONDUCT

Welcome to our practice. Our providers and staff strive to make your dental experience the best it can be. Please be assured that our staff will do all they can to assist you or accommodate your needs. However, the Doctor and staff will not tolerate any of the following:

- Verbal abuse of any kind
- Physical abuse of any kind
- Repeated missed appointments (3 or more no show/canceled appointments)
- Non-compliance of any provider recommended orders including:
- Not taking medications as prescribed
- Not following treatment plan
- Not having ordered referrals done
- Non-payment of balance

Any of the behaviors listed above may result in you being discharged from the practice due to breach of patient code conduct. We feel these behaviors compromise the patient/Doctor relationship and the quality of care we can provide.

____

Patient/Guardian Signature

PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You have the right to refuse to sign this acknowledgment

I, ____________________, have received a copy of this Office's NOTICE OF PRIVACY as required by federal law.

____

Patient/Guardian Signature