How did you hear about our office? _____

New Age Dental

7776 Limonite Ave. Riverside, CA 92509

Patient Name: _____ _____Date of Birth: _____ Sex: M / F Child/Single/Married/Divorced
LAST FIRST PLEASE CIRCLE ONE

Home address: _____ E-mail:_____
STREET APT # CITY ZIP CODE

Social Security: _____ Driver's License#: _____

PLEASE CHECK BEST METHOD OF CONTACT:

□Home# ( ) _____ □Work# ( ) _____ □Cell# ( ) _____ □ Texts □E-mail

Employer: _____ Occupation: _____

Emergency Contact Information:_____ Phone#: ( ) _____ Relationship:_____

- **If patient is under 18 years old please complete:**

Parent or Guardian Name: _____ Date of Birth: _____ Phone#: ( ) _____

Person responsible for account if different from above: _____ SS#_____ Phone#: ( ) _____

- **Insurance information:**

Subscriber Name: _____ Date of Birth: _____ Phone#: ( ) _____

Subscribers Employer: _____ Work# ( ) _____ Group/Policy#:_____

Name of Insurance: _____ ID or SS#: _____

- **Medical/Dental History: (Please Circle appropriate answer)**

Yes/No Is your general health good?
If NO, explain _____

Yes/No Has there been a change in your health within the last year?
If YES, explain_____

Yes/No Have you gone to the hospital or emergency room or had a serious illness in the last 3 years?
If YES, explain_____

Yes/No Are you being treated by a physician now?
If YES, explain_____
Date of last medical exam? _____ Reason for exam?_____

Yes/No Have you had problems with prior dental treatment?
If YES, explain_____ Date of last dental exam: _____

Yes/No Are you in pain now?
If YES, explain_____

- **Have you experienced any of the following? (Please Circle appropriate answer)**

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

- **Have you had or do you have any of the following? (Please Circle appropriate answer)**

Yes/No	Heart Disease	Yes/No	Cosmetic surgery	Yes/No	Eating disorder
Yes/No	Family history of Heart Yes/No Disease	Yes/No	Surgeries	Yes/No	Osteoporosis
		Yes/No	Hospitalization	Yes/No	Thyroid disease
Yes/No	Heart attack	Yes/No	Diabetes	Yes/No	Asthma
Yes/No	Artificial Joint	Yes/No	Family history of Diabetes	Yes/No	Hepatitis
Yes/No	Stomach problems or ulcers	Yes/No	Tumors or Cancer	Yes/No	Sexually transmitted diseases
Yes/No	Heart Defects	Yes/No	Chemotherapy	Yes/No	Herpes
Yes/No	Heart murmurs	Yes/No	Radiation	Yes/No	Canker or cold sores
Yes/No	Rheumatic fever	Yes/No	Arthritis, Rheumatism	Yes/No	Anemia
Yes/No	Skin Disease	Yes/No	Emphysema or other Lung	Yes/No	Liver Disease
Yes/No	Hardening of arteries	disease		Yes/No	Eye disease
Yes/No	High Blood pressure	Yes/No	Kidney or bladder disease	Yes/No	Transplants
Yes/No	Seizures		Stroke	Yes/No	Tuberculosis

- **This information will not be release unless specifically authorized by patient:**

Yes/No AIDS/HIV Yes/No Anxiety Yes/No Depression Yes/No Treatment for emotional condition

- **Women only:** Yes/No Are you or could you be pregnant?

- **Are you Allergic to or have you had a reaction to any of the following? (Please Circle appropriate answer)**

Yes/No Aspirin	Yes/No Valium	Yes/No Percodan
Yes/No Darvon	Yes/No Demerol	Yes/No Nitrous Oxide
Yes/No Codeine	Yes/No Penicillin	Yes/No Metal
Yes/No Latex	Yes/No Erythromycin	
Yes/No Local Anesthetic (Novocain or Xylocaine)	Yes/No Tetracycline	
	Yes/No Vicodin	

Other: _____

- **Are you taking or have you taken any of the following in the last three months?**

Yes/No Recreational drugs	Yes/No Over-the counter medicines	Yes/No Weight-loss medicines
Yes/No Cartico-Steroids	Yes/No Tobacco in any form	Yes/No Alcohol
Yes/No Bisphosphonate (Fosamax)	Yes/No Antibiotics	Yes/No Supplements
Yes/No Aspirins	Yes/No Blood Thinners	

Please list all medications you are currently taking: _____

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

Yes/No Have you ever been premedicated for dental treatment?
If YES, explain_____

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 Signature: _____ Date: _____
Physician's Name:_____ 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.

Patient (or Parent/Guardian) Signature: _____ Date: _____ Dentist Initials: _____

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Dental Financial Policy

Our practice is based on the simple truth that if we satisfy & delight our patients and they achieve the dental results they want, they are more likely to tell others about their dental experience.
Dentistry is not an exact science and therefore reputable practitioners cannot properly guarantee results.

As a courtesy to our patients we will call your Insurance Company to verify benefits.
Ultimately, the patient is responsible for the payment of all services provided by the office regardless of payment by your Insurance. We will not be liable for any misinformation given to us by your Insurance, and recommend that the patient personally contact their Insurance carrier if they should have any questions regarding their benefits prior to starting treatment.

We will be happy to bill your Insurance for your care providing that you give us all the information we need to accurately verify your coverage. Even though you have Insurance coverage please remember that paying for your dental care is your personal responsibility. We expect payment from the Insurance within 30 days. We will automatically transfer and bill you for any payments not received from the Insurance after 45 days. You need to pay us in full at that time unless other arrangements are made with the office.
Any amounts you personally owe and are 30 days late will receive a service charge of 1 ½% per month.

Occasionally the Insurance will send the payment to the patient. If this occurs, you are responsible to bring in the payment along with the explanation of benefits for such paid services to our office immediately.

If your Insurance requests additional information from you to process the claims for services rendered in our office, it's your responsibility to respond to them in a timely manner so they can process the claims for services rendered.

If you suspend, back date or terminate coverage with the Insurance Company while services are being provided, you are responsible to notify our office as soon as possible, and you will be responsible for any unpaid balances on your account.

You will need to pay your portion of the charges as you go. This includes the annual deductible,
Co-payment and charges your Insurance refuses to pay or that are not a covered benefit under your plan.

If you suspend or terminate your dental care against the advice of the doctor, all outstanding balances by you or due by your Insurance Company will become immediately due and payable by you personally before you leave the office.

There is a charge of $50.00 per hour for all broken appointments without a 72 hour notice prior to your scheduled appointment excluding weekends

*We don't accept checks. Our office policy does not allow us to extend credit in house. We do accept **Care credit, Visa, Master Card, American Express, Discover and Debit payments.**

* Once treatment is diagnosed and started in our office, we reserve the right to finish the treatment.
You will be charged and will be responsible for the treatment regardless of whether you return to complete treatment or not. You must return within 2 weeks for delivery of a prosthetic appliance.
In case of undelivered dentures, crowns, bridges, veneers, orthodontic appliances, guards, and any other prosthetic devices that do not fit because you didn't come in on a timely manner for delivery, you will be responsible for the lab fee for the remake. No refunds will be given!

*All balances need to be paid in full before any case can be delivered to you.

* In case of unfinished root canals, fillings, implants, surgery.., you will be responsible for all the costs should it get re-infected, and require re-treatment and /or referral to a specialist.
*If you go to another dental office for treatment started in our office, or decide on your own to change treatment or provider, you may do that at your own expense.
* In the event that you have paid for your accepted treatment by Care-Credit or any other Credit Card and you then decide not to finish treatment and request a refund, you will be responsible to pay our office 14.9% of the total charge made on the Credit Card (this is the fee the Credit Card charges us).

My Signature below certifies that I have read and understand the terms and policies set by Fullerton Dental Care.

Patient Signature_____Date:_____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name:_____

Address:_____

Telephone #: _____**E-Mail:**_____

Social Security #:_____

Section B: To the patient- **READ THE FOLLOWING STATEMENTS CAREFULLY!**

Purpose of Consent: By Signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practice before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of uses and disclosures we may make of your protected health information, and other important matters about your protected health. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our Privacy Practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any reservations of our Notice, at any time by contacting us.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation, of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE:_____

I _____have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to use and disclose my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to patient:_____

Acknowledgement and Authority

I consent to treatment as necessary or desirable to the care of the patient first named above, including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray, or other studies that may be used by attending doctor, or qualified designate. I have received a copy of the Dental Materials Fact Sheet as required by law. I also acknowledge full responsibility for my payment and agree to pay, in full at the time of service, unless other arrangements are made with the Financial department.

Patient Signature:_____ Date:_____

Parent or Guardian Signature (If patient is a minor):_____

Dental Treatment Consent Form

Patient Name: _____ **Birthdate:** _____

Please read and initial the items checked below. Then read and sign the section at the bottom of the form.

❖ WORK TO BE DONE:

I understand that the following work will be done today: ☐X-ray's ☐Exam ☐Cleaning ☐Fluoride ☐Irrigation
☐ Amalgam/Silver Filling ☐Composite/white Fillings ☐Root Canal ☐Crowns ☐ Bridges ☐Extractions ☐Plug ☐Bone Graft
☐Scaling & Root Planning (SRP) ☐Other:_____Initials:_____

❖ 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: _____

❖ 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: _____

❖ 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 paragra40060260001ph #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: _____

❖ CROWNS, BRIDGES AND CAPS Tooth # : _____

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 or color) will be before cementation. Delivery Date: _____ Initials: _____

❖ DENTURES, COMPLETE OR PARTIAL

I understand 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 understand the final opportunity to make changes in my new dentures (including shape, fit, size, placement, color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately 3-12 months after initial placement. The cost for this procedure is not included in the initial denture fee. Delivery Date: _____ Initials: _____

❖ ENDODONTIC TREATMENT (ROOT CANAL) Tooth #:_____

I understand 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: _____

❖ PERIODONTAL LOSS (TISSUE & BONE)

I understand that I have a serious condition, causing gum and bone infection 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.

Irrigation: _____Initials: _____

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for myself or my minor child. I have had full opportunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my satisfaction.

_____	_____	_____	_____
Signature of Patient, Guardian or Personal Rep.	Date	Doctor Signature	Date