Fullerton CRAFT SMILES Dental

Name: _____
Last First MI Title

Preferred Name: _____ DOB: _____ SSN: _____

Address: _____ City _____ State ____ ZIP _____

❑ Male ❑ Female Home Phone: _____ Cell Phone: _____

E-mail Address: _____ (Please print clearly)

Do you prefer to be contacted for appointment confirmation via e-mail, text or phone? _____

Employer: _____ Occupation: _____

How did you hear about our office? ❑ Family/Friend ☐ Internet/Website ☐ Yelp ☐ Mail ☐ Insurance ❑ Physician

If you were referred by a friend or family please share their name so that we may thank them: _____

Primary Insurance

Insurance Company Name: _____ Policy or Group# _____

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to 2K Fullerton Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____ Date _____

Consent: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Signature: _____ Date: _____

DENTAL PATIENT MEDICAL HISTORY

Reason for Dental Visit? _____

If you are unsure of how to answer any of the questions below, please ask dental staff for help! Do you have or have you had any of the following? (please check)

	Yes	No		Yes	No
Organ Transplant -- *Date:*			Epilepsy, Seizures, or Nervous System Disease		
Joint Replacement (hip, knee, ankle, shoulder) -- *Date:*			Stroke		
			Allergy to latex, iodine, or red dye (circle all that apply)		
Artificial Heart Valve -- *Date:*			Allergy to: metal or local anesthetics *(circle)*		
Congenital Heart Disease, Defect, or Heart Murmur:			Cancer/tumors -- *Dates:*		
Bacterial Endocarditis (SBE)			Chemotherapy or Radiation -- *Dates:*		
Kidney Problems or Dialysis *(circle)*			Tuberculosis -- *currently* or *in past* *(circle)*		
Spleen removed			Asthma, or other Lung Disease		
Steroid Use (e.g. prednisone) -- *Dates:*			Ulcers		
HIV or AIDS or do you believe you have been exposed?			Arthritis		
Lupus (SLE)			Osteoporosis		
Rheumatoid Arthritis			Thyroid Problems --- *High* or *Low* *(circle)*		
Diabetes: *Type I* *Type II* *(circle)*			Mental Health Condition:		
Other Immunosuppressive Condition:			Physical or Mental Disability that requires special consideration:		
Hepatitis -- *treated in past* or *currently active*					
Other Liver Disease			Chemical Dependency (alcohol /other drugs)		
Pacemaker / Defibrillator or other Artificial Device / Implant -- *Date*:			Do you smoke or chew tobacco?		
			If yes, are you interested in quitting?		
Congestive Heart Failure			Any other disease or condition?		
Heart Disease or Heart Attack -- *Dates:*					
Chest Pain / Angina			**WOMEN ONLY:**		
High Blood Pressure			Are you pregnant?		
Have you or are you taking blood-thinners?			Are you nursing?		
Anemia or Abnormal Bleeding or Bruising			Are you taking birth control?		

Please circle any of the following medications you have taken (usually for osteoporosis or as part of chemotherapy):
IV - Zometa (Zoledronate), IV - Aredia (Pamidronate), IV - Bonefos (Clodronate), Fosamax (Alendronate), Neridronate, Boniva (Ibandronate), Actonel (Risedronate), Didronel (Etidronate), Skelid (Tiludronate), Loron, Olpadronate.

Would you like to discuss the any of the following today: Invisalign ☐ Whitening ☐ Veneers/Lumineers ☐ Implants ☐ Amalgam Removal ☐ Night Guard ☐ Traditional Orthodontics ☐

List any medications that you are allergic to or which make you sick: _____

List medications you currently take (including over-the-counter drugs): _____

Date of last medical appointment_____ Primary Care Provider Name _____

Do you require antibiotics for dental treatment? Yes/No Do you like your smile? Yes/No

Have you ever had an unfavorable dental experience? Yes/No Are your teeth sensitive to hot/cold/pressure/anything else? Yes/No

Have you ever had a serious problem with any prior dental work? Yes/No

IMPORTANT! The answers I have given above are true to the best of my knowledge. I am signing below on behalf of myself or the below named minor in my guardianship.

_____ _____

Signature (Patient or guardian if patient is a minor) *Date*

PROVIDER REVIEW (Date/Initials)
(for paper records only)

_____ _____
_____ _____
_____ _____

Fullerton Craft Smiles Dental

NOTICE OF PRIVACY PRACTICES

Agreement by signing this form, you agree that you were given a copy of the Notice of Privacy Practices of *Fullerton Craft Smiles Dental*. Our Notice of Privacy Practices explains how we may use and share your protected health information. Please read it all the way through.

Our Notice of Privacy Practices may change. If we make any changes, you can get a copy of the new notice by calling us at (714) 526-2828 or by going to *Fullerton Craft Smiles Dental* at 1010 E Chapman Ave, Fullerton, CA 92831.

If you have any questions about our Notice of Privacy Practices, please call our office at (714)526-2828.

I agree that I have been given a copy of the Notice of Privacy Practices of Fullerton Craft Smiles Dental.

Name: _____

Signature: _____ Date: _____
(patient/parent/conservator/guardian)

IF AGREEMENT CANNOT BE SIGNED

Fill this part in only when it is not possible to get an individual to sign this form.
Describe the good faith efforts made to get the individual's agreement, and the reasons why the form was not signed:

_____

_____

_____

_____

Provider Signature: _____ Date: _____

Fullerton
CRAFT SMILES
Dental

Financial Policy Acknowledgment

The following information is to inform you of our financial policy. If, at any time, you have questions regarding this policy, please do not hesitate to ask any member of our dental team.

We are committed to providing you with the highest quality of care; our fees are a reflection of the quality of care we provided. We continue our commitment by offering a variety of financial options to enable you to receive the dental care you need. We accept **cash**, **VISA**, **MasterCard**, **American Express** and **Discover**. We have also partnered with **Care Credit** a third-party company to offer the flexibility of no interest as well as extended payment options.

We will communicate all recommended treatment options and associated fees prior to the start of treatment. Payment is expected at the time of treatment. A delinquent account impedes our ability to provide you with quality dental care that you deserve. It is our policy that the guardian who accompanies a child to our office for treatment is responsible for payment of all services rendered.

We are committed to respecting your time and ask that you make every effort to keep the appointment time reserved exclusive for you. We understand there may be times when you are unable to keep you schedule appointment, however, we do ask that you provide our office with a 24 hour notice should you need to reschedule. **(without providing us a 24hr notice there is a $50.00 fee charged to the patient)**

As a courtesy to our patients with dental insurance benefits, we will submit and provide any necessary information to assist you in receiving your dental benefits. We require that any applicable deductibles and estimated patient portion be paid at the time treatment is rendered. We do accept assignment of benefits (meaning that in most cases the dental insurance check can be paid to our practice) to help reduce your immediate out-of-pocket expense. We **can't guarantee payment from an insurance company** and any remaining balance left after insurance payment is patient's responsibility.
If you have a direct reimbursement policy, payment in full is expected on the day of service and your dental plan will reimburse you.
It is your responsibility to understand the type of dental insurance you have and the benefits selected by you and/or your employer.

- You (not the insurance company) are responsible for the fee of services rendered.

_____ _____

Signature of patient/or guardian Date

Informed Consent
General Dentistry

Chart # _____

All patients complete 1 thru 4 below, and 5 thru 10 as needed.

1. EXAMINATIONS AND X-RAYS

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. I understand I am to have work done as detailed in the attached treatment plan.

(Initials _____)

2. DRUGS, MEDICATION AND SEDATION

I have been informed and 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). I have informed the Dentist of any known allergies. They may cause drowsiness, 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 al 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 or oral contraceptives (birth control pills).

(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 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, the cost of which is my responsibility.

(Initials _____)

5. FILLINGS

I understand that a more extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure found during preparation. This may lead to other measures necessary to restore the tooth to normal function. This may include root canal, crown, or both. I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I understand that sensitivity is a common after effect of a newly placed filling.

(Initials _____)

6. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crown, 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, exposed sinuses, 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 that 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 _____)

7. CROWNS, BRIDGES, VENEERS AND BONDING

a. 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 veneer (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 affect tooth surfaces and may require modification of daily cleaning procedures. It is also my responsibility to return for permanent cementation within 20 days after tooth preparation. Excessive delays may allow for decay, tooth movement, gum disease, and/or bite problems. This may necessitate a remake of the crown, bridge, or veneer. I understand there will be additional charges for remakes or other treatment due to my delaying permanent cementation.

(Initials _____)

b. I am electing to follow the Dentist's recommendation of using high noble instead of base metal in my crown and bridge restorations.

(Initials _____)

c. I am electing to do a fixed bridge or implant replacement of missing teeth instead of a removable appliance. I understand that this fixed bridge or implant and crown may not be a covered benefit under my insurance policy.

(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. Immediate dentures (placement of dentures immediately after extractions) may be uncomfortable at first. Immediate dentures may require several adjustments and relines. A permanent reline or a second set of dentures will be necessary later. This is not included in the initial denture fee. 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. I understand that is my responsibility to return for delivery of dentures. I understand that failure to keep delivery appointments may result in poorly fitted dentures. If a remake is required due to my delay of more than 30 days, there will be additional charges.

(Initials _____)

9. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, that complications can occur from the treatment, and that occasionally, canal material may extend through the root tip which does not necessarily affect the success of the treatment. The tooth may be sensitive during treatment and even remain tender for a time after treatment. Hard to detect root fracture is one of the main reasons root canals fail. Since teeth with root canals are more brittle than other teeth, a crown is necessary to strengthen and preserve the tooth. I understand that endodontic files and reamers are very fine instruments and stresses can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root can treatment (Apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it.

(Initials _____)

10. PERIODONTAL TREATMENT

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 cleanings as directed, follow a health diet, avoid tobacco products and follow other recommendations. I understand that periodontal disease may have a future adverse affect on the long-term success of dental restorative work.

(Initials _____)

11. BLEACHING

Bleaching is a procedure done either in office (approximately 1 hour) or with take-home trays (several treatments over 2-4 weeks). The degree of whitening varies with the individual. The average patient achieves considerable change (1-3 shades on the dental shade guide). Coffee, tea and tobacco will stain teeth after treatment and are to be avoided for at least 24 hours after treatment. I understand I may experience sensitivity of the teeth and/or gum inflammation, which will subside when treatment is discontinued. The Dentist may prescribe fluoride treatments for rare cases of persistent sensitivity. Carbamide peroxide and other peroxide solutions used in teeth bleaching are approved by the FDA as mouth antiseptics. Their use as bleaching agents has unknown risks. Acceptance of treatment means acceptance of risk. Pregnant women are advised to consult with their physician before starting treatment.

(Initials _____)

12. NITROUS OXIDE

I elect to have nitrous oxide in conjunction with my dental treatment. I have been informed and understand the possible side effects that may occur. These include, but are not limited to nausea, vomiting, dizziness and headache. I understand that nitrous oxide use is not indicated if I am pregnant.

(Initials _____)

13. DENTAL BENEFITS

I understand that my insurance may provide only the minimum standard of care. I understand that submitting insurance and receiving a benefit is my responsibility. I elect to follow the Dentist's recommendation of optimal dental treatment.

(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 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 no other Dentist or corporate entity, other than the treating Dentist, is responsible for my dental treatment. I acknowledge the receipt of and understand post-operative instructions and have been given an appointment date to return.

Signature: _____

Date: _____

Doctor: _____

Date: _____