MD Name:
Phone #:

SCRIPPS
FAMILY & COSMETIC DENTISTR

Dental Health History

Patient name_____ Date of Birth_____
Previous Dentist and location_____
Last cleaning (circle one): 6mo 1yr 2-5yr 6-10yr 11-15yr 15+yr other_____
How many times per day do you brush: 0 1 2 3 4 **Floss:** 0 1 2 3 4 **Rinse:** 0 1 2 3 4
Rate your level of dental anxiety: none mild moderate severe **Sodas/day (diet or regular):** 0 1 2 3 4 5+
Specific area of concern: NO YES, _____
Allergies to medications: NO YES, _____
Please list any medications you are taking: _____
Are you pregnant, nursing or trying to get pregnant?: NO YES, _____
Have you ever taken "fen-phen"?: NO YES, _____
Have you ever taken Fosamax, or any other Bisphosphonate?: NO YES, _____

Do you have or have you ever had the following (circle Yes or No):

Latex allergy	Y	N	Circulatory problems	Y	N	Mitral valve prolapse	Y	N
Bleeding gums	Y	N	Congenital heart lesions	Y	N	Nervous problems	Y	N
Tobacco Use	Y	N	Diabetes type: I II	Y	N	Psychiatric care	Y	N
Grinding teeth	Y	N	Emphysema	Y	N	Respiratory treatment	Y	N
Sores/Growths	Y	N	Epilepsy	Y	N	Rheumatic fever	Y	N
AIDS/HIV	Y	N	Fainting or dizziness	Y	N	Scarlet fever	Y	N
Anemia	Y	N	Glaucoma	Y	N	Shortness of breath	Y	N
Artificial heart valves	Y	N	Heart murmur	Y	N	Sinus trouble	Y	N
Artificial joints	Y	N	Heart problems	Y	N	Stroke	Y	N
Asthma	Y	N	Hepatitis type: A B C	Y	N	Swollen neck glands	Y	N
Abnormal bleeding	Y	N	Herpes	Y	N	Thyroid problems	Y	N
Blood disease	Y	N	High blood pressure	Y	N	Tuberculosis	Y	N
Cancer	Y	N	Kidney disease	Y	N	Tumor/Growth	Y	N
Chemical dependency	Y	N	Liver disease	Y	N	STD _____	Y	N
Chemotherapy	Y	N	Low blood pressure	Y	N	Other:_____		

I certify that the above information is true and correct and that false information can seriously compromise my health by treatment at this office. I will notify the office of any changes immediately.

Signature_____ **Date**_____

Doctor's Signature_____ Date_____

Doctor's Comments_____

_____

Updates-once per year

Changes/new medications: NO YES, _____ Initials_____ Date_____
Changes/new medications: NO YES, _____ Initials_____ Date_____
Changes/new medications: NO YES, _____ Initials_____ Date_____
Changes/new medications: NO YES, _____ Initials_____ Date_____

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Confidential Patient Information

Patient's full name_____ Date of Birth_____
Home address_____ City, state, zip_____
Cell phone (____) _____ Home (____) _____ Work (____) _____
Social security number_____ Drivers license_____
□Married □Single □Divorced □Minor child □FT College (School name, location_____)
Employer name_____ Phone_____ Occupation _____

EMERGENCY CONTACT_____ **Phone**_____ **Relation**_____

How did you hear about us? Google Facebook Yelp Insurance Friend (name_____)

In an effort to be environmentally responsible, we no longer send out paper postcard reminders. We also send appointment reminders via email or text message. **No spam** we promise!

□ I prefer email reminders. EMAIL ADDRESS_____
□ I prefer text reminders. CELL PHONE (____)_____

Insurance name_____ Phone (_____)_____ID_____
Subscriber name_____ Date of birth_____
Social security number_____ Relationship to patient_____
Employer name_____ Group number_____ Occupation_____
Is there a secondary insurance plan? NO YES, _____

Cancellation policy- As a condition of your treatment by this office, please call 24 hours (one full business day) in advance if cancellation or rescheduling of any appointment is necessary to avoid a $85 cancellation charge per hour reserved. I understand I am responsible for giving 24 hour notice to cancel any appointment or I will be charged $85 per hour reserved for me. Three failed appointments will result in dismissal from this practice. **(Initials_____)**

Consent for services-As a condition of your treatment by this office, financial arrangements must be made prior to all dental treatment. All applicable co-payments are due at the time of service, without exception. I understand that I am fully responsible for all charges, whether or not paid by my insurance. I prefer Scripps Family & Cosmetic Dentistry to bill my insurance and assign all insurance benefits, otherwise payable to me for services I receive. I authorize to release any information needed to process claims, billing, legal and collection matters. **(Initials_____)**

Your privacy- The privacy of your information is very important to us. We understand that your private information is confidential and we are committed to protecting it. We create a record of care you receive in our office. We need this record to provide you with quality care and to comply with federal and state laws. The NOTICE OF PRIVACY PRACTICES will tell you about ways we may legally use your information. A laminated copy of this notice is available for you to review and copies are available by request. We respect your privacy. We will never (ever) sell your information. We will use it strictly as needed for treatment, payment and healthcare operations. **(Initials_____)**

I have read the above conditions of treatment at Scripps Family & Cosmetic Dentistry and I certify under penalty of perjury that the above information is true to the best of my knowledge. I am responsible to notify the office immediately if any changes in address, insurance or other important information occurs.

Signature of patient or responsible party (if minor)_____ **Date**_____

SCRIPPS

FAMILY & COSMETIC DENTISTRY

Informed Consent for Dental Services

Patient name_____ **Date**_____

1. **WORK TO BE DONE**-I understand that I am having some or all of the following work done: Exam, x-rays (mandatory for all new patients) and prophylaxis cleaning. Cost of treatment at any specialist is my direct financial responsibility which my insurance may or may not cover. **(Initials_____)**
2. **DRUGS AND MEDICATIONS**-I understand that antibiotics, analgesics, anesthetics and other medications/materials can cause reactions in the human body. Symptoms may include increased heart rate, cold sweat, shaking, redness, swelling, pain, itching, vomiting and/or anaphylactic shock. It is my responsibility to immediately inform the dentist if I have ever had a reaction from a drug or in a dental office or if I experience any of these above symptoms. If I am required to premedicate, I understand that the dentist will not begin treatment until I have taken my appropriate dosage of antibiotics prior to treatment. I understand there is no way for the dentist to predict if I will have a reaction. **(Initials_____)**
3. **CHANGES IN TREATMENT**-I understand that when the dentist does an exam on me, he will diagnose treatment based on findings from my x-rays and clinical oral exam. Dentistry is not an exact science and therefore reputable practitioners cannot guarantee outcome or results. Occasionally, additional treatment may be diagnosed that were not discovered during the exam. I acknowledge that no guarantee or assurance has been made to me regarding the dental treatment which I have requested and authorized. I understand failure to follow diagnosis can result in irreversible damage to my health. **(Initials_____)**
4. **REMOVAL OF TEETH**-Tooth removal is permanent and irreversible. Alternative treatment (if any) has been explained to me. I authorize the dentist to remove my tooth/teeth. I understand that removing a tooth does not always remove infection, if present. The risks involved in having teeth removed may be pain, swelling, spread of infection, dry socket, broken roots, and loss of feeling in my adjacent teeth, tongue, and surrounding tissue (parethesia). Replacement of removed teeth is an additional cost. **(Initials____)**
5. **CROWNS, VENEERS, BRIDGES**-I understand that it is not always possible to match the color of natural teeth exactly with artificial teeth. Temporary crowns are placed for two weeks. If the temporary comes off, I must immediately contact the office to have it repaired/replaced otherwise it may be necessary to start the entire procedure over. Delays in returning for the final fitting will also have this result, the cost of which is my responsibility. There may also be cosmetic options available to me if I choose to have an aesthetic crown placed rather than a standard crown. **(Initials_____)**
6. **ROOT CANAL THERAPY**-Root canal therapy is an attempt to save a tooth. There is no guarantee that root canal therapy will save my tooth. Complications can occur and despite all efforts made by reputable practitioners, there is a possibility the tooth may need to have additional treatment or may need to be removed. In the case that the root canal treatment is unsuccessful, needs to be retreated or the tooth needs to be pulled, I understand that my payment will not be refunded and that any additional treatment will be my financial responsibility. **(Initials_____)**
7. **DEEP CLEANING**-I understand that I have a serious condition causing gum disease and bone loss which can progress to the loss of my teeth. I understand that a deep cleaning removes the bacterial build up below my gum line and I will be anesthetized. Mild discomfort may occur following treatment, this is temporary. **(Initials_____)**
8. **FILLINGS**-I understand that fillings are a conservative approach to treat tooth decay. Marked sensitivity may occur for several days or weeks following treatment, this is normal. If the decay is "deep" into the tooth, there is a possibility the tooth may need a root canal and crown. There is no guarantee or warranty of the success of a filling. If further treatment is needed on the tooth I will not be refunded for the filling and will be responsible for any costs associated with the additional treatment. No guarantee has been made to me regarding the outcome of this treatment. **(Initials_____)**
9. **DENTURES**-I understand that full or partial dentures are constructed of a combination of plastic, resin, acrylic, metal and porcelain. Wearing dentures can be painful and difficult at times. Sore spots, altered speech, and difficulty eating are common problems. Dentures and/or natural teeth may require considerable adjusting and several relines to reach my maximum comfort. These fees are not included in the denture fee. I understand that is my responsibility to return for each fitting visit until the dentures are completed. Delaying these appointments can result in poorly fitted dentures. Remake of dentures due to my delays will cost me time and additional fees. **(Initials____)**
10. **WHITENING**-Whitening is an elective procedure. I understand that whitening results can vary drastically from patient to patient. No warranty or guarantee has been made to me regarding the success of whitening treatment or shade level I may achieve. I understand that a refund will not be issued for whitening services or products for any reason. Some mild and temporary sensitivity may occur during the course of treatment, this is normal and will subside. **(Initials_____)**

By signing below, I am acknowledging that I understand the terms stated and all of my questions have been answered. I choose to proceed with the treatment I have initialed above.

Patient or Guardian signature_____ **Date**_____

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