HE. TH HISTORY & REGISTRA ON

PATIENT INFORMATION

Patient Name: LAST_____ FIRST_____ Middle ___ Sex: M F Birthdate:_____ AGE:____

Soc. Sec # _____ If patient is a minor, give Parent's/guardian's Name _____

Who may we thank for referring you to our office? _____ Today's Date_____

RESPONSIBLE PARTY INFORMATION

Last Name_____First_____ Middle _____ Marital Status_____

Residence Street_____ City_____ State_____ Zip_____

Home Phone (___)_____ Cell Phone (___)_____ Work Phone (___)_____ Email_____

Social Security #_____ Driver's Lic # _____ Birthdate_____

Relation to patient_____ Employer_____Occupation_____

Preferred contact method (please circle): Cell Phone/Text Msg Email Home Phone

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Emergency Contact Not Living With You

Name_____Relationship_____

Cell/Home Number (___)_____

Responsible Party Spouse

Name_____

Cell/Home Number (___)_____

DENTAL HISTORY

How long since you have seen a dentist? _____

Are you having problems now? Y N

Describe_____

Is your present dental health POOR? Y N

Do you wear DENTURES? (Partial or full) Y N

Are you UNHAPPY with your dentures? Y N

Are you APPREHENSIVE about dental treatment? Y N

Have you had PERIODONTAL disease? Y N

Do your gums BLEED, feel TENDER, or IRRITATED? Y N

Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)

Are you UNHAPPY with the APPEARANCE of your teeth? Y N

Are you aware of GRINDING or CLENCHING your teeth? Y N

Do you have HEADACHES/EARACHES or NECK PAIN? Y N

Have you worn BRACES? Y N

Do you have DISCOLORED teeth that bother you? Y N

Would you like your smile to LOOK BETTER or different? Y N

Do you REGULARLY use DENTAL FLOSS? Y N

Are you **ALLERGIC** to the following medications? (please circle)

Penicillin, Aspirin, Codeine, Local Anesthetic, Nitrous Oxide,

Erythromycin, Latex or NONE of the above. Other_____

MEDICAL HISTORY

Do you have any current health problems?_____ Y N

Are you under a physician's care now? _____Y N

For what? _____

What medications are you currently taking?_____

Are you pregnant?_____Y N

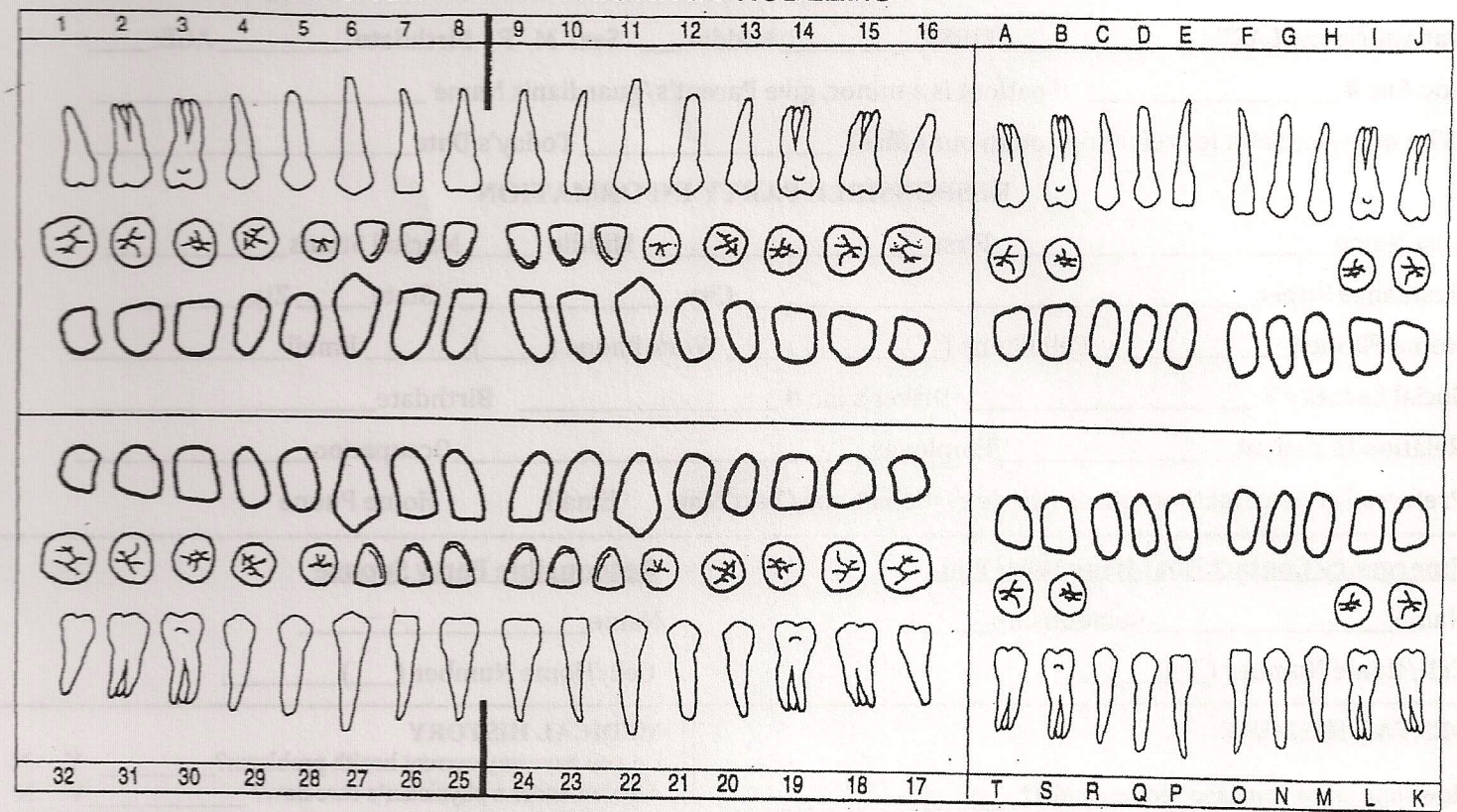
Do you smoke? _____ Y N

Circle any of the following which you have had or presently have:

Alcoholism	Heart Pacemaker
AIDS/A.R.C/HIV Pos.	Heart Surgery
Angina Pectoris	Hemophilia (bleeding problems
Anorexia	Hepatitis
Arthritis	Herpes
Artificial Heart Valve	High Blood Pressure
Artificial Joints (Hip/Knee)	Kidney Disease
Asthma	Latex sensitivity
Back problems	Liver Disease
Bloody cough	Migraines/Headaches
Blood disease	Mirtal Valve Prolapse
Blood Transfusion	Nervousness
Chemotherapy	Psychiatric Treatment
Circulatory problems	Radiation Treatment
Congenital Heart Lesions	Respiratory disease
Cortisone Treatment	Rheumatic Fever
Diabetes	Scarlet Fever
Drug Addiction	Skin Rash
Emphysema	Sinus Trouble
Epilepsy/Seizures	Stroke
Fever Blisters	Tuberculosis (TB)
Heart Disease/Attack	OTHER:_____
Heart Murmur	_____

Patient Signature (Parent of Child)_____ Date: Dentist Signature:_____

DIAGNOSIS: MISSING TEETH AND EXISTING PROBLEMS



TREATMENT PLAN

DATE COMPLETED	TOOTH #	SURFACE	DESCRIPTION	FEE	DATE COMPLETED	TOOTH #	SURFACE	DESCRIPTION	FEE
			EXAMINATION			13-J			
			X-RAY: PANORAMIC: FMX: BWX:			14			
			DIAGNOSTIC MODELS			15			
			PROPHYLAXIS (CLEANING)			16			
			NITROUS-OXIDE GAS			17			
			QUADS UR UL			18			
			SCALING LR LL			19			
			ROOT PLANING			20-K			
	1					21-L			
	2					22-M			
	3					23-N			
	4-A					24-O			
	5-B					25-P			
	6-C					26-Q			
	7-D					27-R			
	8-E					28-S			
	9-F					29-T			
	10-G					30			
	11-H					31			
	12-I					32			

OPTIONAL TREATMENT

DATE COMPLETED	TOOTH #	SURFACE	DESCRIPTION	FEE	DATE COMPLETED	TOOTH #	SURFACE	DESCRIPTION	FEE

INITIAL PERIODONTAL EXAM

GINGIVAL INFLAMMATION	☐ Slight	☐ Moderate	☐ Severe
SOFT PLAQUE BUILDUP	☐ Slight	☐ Moderate	☐ Heavy
HARD CALC. BUILDUP	☐ Light	☐ Moderate	☐ Heavy
STAINS	☐ Light	☐ Moderate	☐ Heavy
HOME CARE EFFECTIVENESS	☐ Good	☐ Fair	☐ Poor
PERIDONTAL CONDITION	☐ Good	☐ Fair	☐ Poor
PERIDONTAL DIAGNOSIS	☐ Normal	☐ Gingivitis	
PERIODONTITIS	☐ Early	☐ Moderate	☐ Advanced

MUCOGINGIVAL DEFECTS #s_____

PERIODONTAL RECALL	DENTAL RECALL

CLINICAL DATA

OCCLUSION: ☐ Class I ☐ Class II ☐ Class III ☐ Crossbite:_____

T.M.J. ☐ Normal ☐ Popping ☐ Deviation ☐ Tooth Wear ☐ Pain

☐ INITIAL SOFT TISSUE EXAM ☐ NEGATIVE

☐ Lips ☐ Floor of Mouth ☐ Palate ☐ Tongue ☐ Neck & Nodes

PATIENT'S TREATMENT DECISIONS

☐ DOCUMENTATION OF DENTAL RECORD COMPLETED

☐ PATIENT INFORMED OF TX RECOMMENDATIONS AND CONSENTS TO TX (ALTERNATIVE DISCUSSED)

☐ PATIENTS WANTS NO TX OR PARTIAL TX INFORMED OF CONSEQUENCES AND RISKS INVOLVED.

INITIAL PERIODONTAL EXAM

X-RAYS TAKEN ☐ FM-PAS ☐ BMX ☐ PANO ☐ OTHER_____

☐ NO BONE LOSS

☐ SLIGHT BONE LOSS (04600)

☐ MODERATE BONE LOSS (04700)

☐ MAJOR BONE LOSS (04800)

☐ BEGINNING FURCATION (04700)

☐ ADVANCED FURCATION (04800)

☐ OTHER_____

UR	UL	LR	LL

SHADE

Teeth	Upper	Lower
Cents		
Lats		
Cusp		
Posts		

PERIODONTAL SCREENING & RECORDINGS

SEXTANT SCORE

MONTH DAY YEAR

EXISTING PROSTHESIS:

MAX._____ DATE PLACED:_____ CONDITION:_____

MAND._____ DATE PLACED:_____ CONDITION:_____

REFERRALS:

PERIO._____ ORTHO:_____ ENDO:_____

ORAL SURG:_____ M.D.:_____ OTHER:_____

COMMENTS

CONSENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible to all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to my overdue balance. I understand that where appropriate, credit reports may be obtained.

PATIENT Signature (Parent of Child)_____ Date:_____ Dentist Signature:

INFORMED CONSENT

PATIENT NAME _____ CHART NO. _____

1. WORK TO BE DONE

I understand that I am having the following work done: Fillings ☐, Bridges ☐, Crowns ☐, Extractions ☐, Impacted Teeth Removed ☐, Root Canals ☐, Dentures ☐, Partials ☐, Periodontics ☐, Other ☐

2. DRUG AND MEDICATIONS

I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, vomiting, and/or anaphalactic shock (severe allergic reaction).

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the Dentist to make those changes 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 other necessary under 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 risk involved in having teeth removed, some of which are pain, swelling, spread of injection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Parasthesia) 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.

5. ANESTHESIA

I realize the risks involved in receiving a local anesthetic, some of which are: partial facial paralysis, inflamed tissue, adverse reactions to drugs causing cardiac arrest, miscarriage; hemorrhage, nerve damage and/or numbness.

6. CROWNS, 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, and that if I don't have the permanent crown(s) placed permanent serious damage or loss of the tooth/teeth involved my ensue, and that if I delay placement I may cause the teeth involved to move so that the permanent crown no longer will fit properly.

7. 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, and relining due to tissue and bone change.

8. 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 effect the success of the treatment, and that this treatment often requires multiple visits and that I can cause serious damage or loss of the tooth/teeth involved if I do not complete the prescribed treatment.

9. PERIODONTAL LOSS (TISSUE AND 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. The alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions.

(Initials)_____

I hereby request and authorize the Dentists, and their Staff, to perform dental work upon me for the purpose of attempting to improve my appearance, function and the health of my mouth, teeth, bone and tissues, as explained above.

The effect and nature of the proceeding to be performed, and risks involved, as well as the possible alternative methods of treatment have been fully explained to me.

I also authorize the operating Dentist and Assistants to perform any other procedure which they may deem necessary or desirable in attempting to improve the condition stated on the diagnostic treatment form, or treat unhealthy or unforeseen conditions that may be encountered during the operation.

I know that the practice of Dentistry and surgery 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 treatment which I have herein requested and authorized.

Alternatives and possible bad reactions have been explained to me in detail. Complications, such as infection, hemorrhage and/or bleeding, scarring, contraction, possible deformities, prolonged healing time over the estimate, reaction to any drugs before, during and after surgery, numbness or itching of the tongue, lip, teeth, tissues (Parasthesia), fractured jaw, etc., have been clearly explained to me.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT AND THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE. ANYTHING I DID NOT UNDERSTAND HAS BEEN EXPLAINED TO ME.

Signature: _____ Date: _____

Patient or Legal Representative

Witness: _____ Date: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT — PLEASE 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 Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. 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 revisions of our Notice, at any time by contacting:

Contact Person: Dr. Jesus Flores

Telephone: (909)792-0071 Fax: _____

E-mail: drjflores@aol.com

Address: 1585 W. Redlands Blvd

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 your use and disclosure of 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: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.