Dental Health History Form

Patient name: _____ _____ _____ _____

First Middle Last Nickname

What are your goals in coming to our practice today?_____

What is important to you in a dentist or dental practice? _____

What has been your experience with the dentist in the past? _____

Date of last radiographs (x-rays) and exam: _____

Date of last hygiene continuing care appointment (cleaning or periodontal maintenance): _____

Former Dentist: _____ Address: _____ Phone: _____

If you left your previous dentist, what are your reasons? _____

Have you had problems with prior dental treatment? _____

Are you experiencing any pain now? □ Yes □ No

If yes, please explain: _____

Have you ever been pre-medicated for dental treatment? □ Yes □ No

If yes, why? _____

Have you ever been anxious about having dental treatment? □ Yes □ No

If yes, would you be comfortable sharing why? _____

Would you like to discuss this concern with the doctor to learn about your relaxation options? _____

Do you currently have the following concerns with your oral health or smile? (Please check Yes or No)

□ Yes □ No Clenching or grinding teeth
□ Yes □ No Crowding/crooked teeth
□ Yes □ No Discolored teeth
□ Yes □ No Dry mouth/bad breath
□ Yes □ No Missing teeth
□ Yes □ No Loose tooth/teeth
□ Yes □ No Uncomfortable bite
□ Yes □ No Unhappy with appearance of teeth
□ Yes □ No Old fillings (Gold or Silver)
□ Yes □ No Overbite
□ Yes □ No Underbite
□ Yes □ No Speech problems
□ Yes □ No Tooth sensitivity to hot/cold
□ Yes □ No Jaw joint pain (TMJ)
□ Yes □ No Old crowns
□ Yes □ No Too much gum tissue when I smile
□ Yes □ No Spaces between teeth
□ Yes □ No Tooth shape/size
□ Yes □ No Difficulty chewing
If yes, where?_____
□ Yes □ No Food gets caught between teeth
If yes, where?_____

Have you ever had orthodontic treatment? □ Yes □ No

If yes, when?_____

Have you ever had periodontal (gum tissue) treatment? □ Yes □ No

(Such as deep cleanings, root planning, or periodontal surgery?

If yes, when?_____

Have you had your teeth whitened in the past? □ Yes □ No

If yes, what method?_____

Are you interested in any of the following? (please check Yes or No)

□ Yes □ No At-home oral hygiene care
□ Yes □ No Dental implants
□ Yes □ No How to prevent periodontal disease
□ Yes □ No Veneers
□ Yes □ No Orthodontic treatment
□ Yes □ No Periodontal treatment during pregnancy
□ Yes □ No Teeth whitening
□ Yes □ No Tooth-colored fillings
□ Yes □ No Oral hygiene care for infants and toddlers

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or my patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Signature of patient, parent, or guardian Date

(Please type your name in the space provided above to electronically sign your name)

san diego dental studio
Dr Tom Bierman | Dr Quan Ma

PATIENT INFORMATION

Patient's name:_____ Preferred name:_____ Birth date:_____

If minor, parent's name:_____

Home phone:_____ Work phone:_____ Cell phone:_____

Email address:_____ Preferred method of contact:_____

Mailing address:_____ City:_____ State:_____ Zip code:_____

Employer:_____ Occupation:_____

Spouse's name:_____ Spouse's employer:_____ □ Unmarried

Emergency contact name: _____ Emergency contact phone:_____

Who may we thank for referring you to our office?_____

BILLING, CREDIT, AND INSURANCE INFORMATION: □ Not covered by dental insurance

Social Security number:_____ Dental insurance co.: _____ Group number:_____

Covered by spouse's insurance? □ Yes □ No

Spouse's dental insurance company:_____ Group number:_____

Spouse's birth date:_____ Social Security number:_____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check Yes or No)

□ Yes □ No Cancer or tumor
□ Yes □ No Heart ailment or angina
□ Yes □ No Heart murmur, mitral valve prolapse, heart defect
□ Yes □ No Rheumatic fever or rheumatic heart disease
□ Yes □ No Artificial joint or valve
□ Yes □ No High or low blood pressure
□ Yes □ No Pacemaker
□ Yes □ No Tuberculosis or other lung problems
□ Yes □ No Kidney disease
□ Yes □ No Hepatitis or other liver disease
□ Yes □ No Alcoholism
□ Yes □ No Blood transfusion
□ Yes □ No Diabetes
□ Yes □ No Neurologic condition
□ Yes □ No Epilepsy, seizures, or fainting spells
□ Yes □ No Emotional condition
□ Yes □ No Arthritis
□ Yes □ No Herpes or cold sores
□ Yes □ No AIDS or HIV positive
□ Yes □ No Migraine headaches or frequent headaches
□ Yes □ No Anemia or blood disorders
□ Yes □ No Abnormal bleeding after extractions, surgery, or trauma
□ Yes □ No Hayfever or sinus trouble
□ Yes □ No Allergies or hives
□ Yes □ No Asthma
□ Yes □ No Do you snore or have you been told that you snore?
□ Yes □ No Have you been previously diagnosed with sleep apnea?
If yes, do you use a CPAP? □ Yes □ No
□ Yes □ No Do you smoke or use chewing tobacco?

Are you **allergic** to, or have you reacted adversely to any of the following?
(Please check Yes or No)

□ Yes □ No Latex materials
□ Yes □ No Penicillin or other antibiotics
□ Yes □ No Local anesthetics ("Novocain")
□ Yes □ No Codeine or other narcotics
□ Yes □ No Sulfa drugs
□ Yes □ No Barbiturates, sedatives, or sleeping pills
□ Yes □ No Aspirin
Other:_____

Are you taking any of the following? (Please check Yes or No)
□ Yes □ No Aspirin
□ Yes □ No Anticoagulants (blood thinners)
□ Yes □ No Antibiotics or sulfa drugs
□ Yes □ No High blood pressure medicine
□ Yes □ No Antidepressants or tranquilizers
□ Yes □ No Insulin, Orinase, or other diabetes drug
□ Yes □ No Nitroglycerin
□ Yes □ No Cortisone or other steroids
□ Yes □ No Osteoporosis (bone density) medicine
Other:_____

Women: (Please check Yes or No)
□ Yes □ No Are you pregnant?
If yes, expected delivery date is:_____
□ Yes □ No Taking hormones or contraceptives

Name of your physician:_____

Do/did you have any diseases, surgery, or problem not listed above?_____

Please write all medications you are taking:_____

Print name:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or my patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Signature of patient, parent, or guardian Date

(Please type your name in the space provided above to electronically sign your name)

Office Policy on Insurance

We are pleased to bill your insurance for you, but it is extremely difficult for us to keep track of all the individual requirements of the numerous insurance plans. Each plan has different stipulations regarding how often services may be rendered and what the plan will cover for the specific services.

Even within the same insurance company, the plans differ widely depending upon what type of contract your employer has negotiated.

Providing quality dental care for our patients is our primary concern. We are more than willing to provide that care within your insurance contract guidelines if you let us know at EACH time of service exactly what those guidelines are.

Unfortunately, if you do not know or do not inform us of any special requirement in your insurance contract and you subsequently have treatment that is not covered. We will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility.

We understand that sometimes the patient does not know what is covered and what is not. However, often we do not and cannot know either.

With your knowledge and awareness of your own insurance agreement, you should be able to receive all of the benefits offered to you, and we will be able to concentrate on caring for your dental needs.

I have read and understand the office policy stated above and agree to accept responsibility as described. I agree to accept this responsibility for the duration of my care.

_____ _____ _____

Patient Signature Date Witness

_____ _____

Patient Name (Please Print) Witness (Please Print)

6635 Flanders Drive, Suite E, San Diego, CA 92121
T 858.457.4100 F 858.457.5200

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I,_____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

san diego dental studio

Dr Tom Bierman | Dr Quan Ma

Informed Consent

1. Changes to the Treatment Plan: I understand that during dental 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 treatment plan can either increase or decrease the original estimate. I understand that I will be informed of the recommended change and will have the opportunity to accept or decline the procedure.

   (Initials_____)

2. Potential risks/side effects of treatment: I understand that symptoms of popping, clicking, grinding, locking, and pain can intensify or develop in the joint of the lower jaw (TMJ) subsequent to routine dental treatment, wherein the mouth is held in the open position. Although symptoms of Temporo-mandibular joint dysfunction associated with dental treatment are usually temporary in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I may be referred to a specialist for treatment, the cost of which is my responsibility. Additionally, I understand that antibiotics, analgesics, and other medications may cause adverse reactions, some of which are, but not limited to, redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, or cardiac arrest. Occasionally, injection of a local anesthetic may cause prolonged, persistent anesthesia, numbness, and/or irritation to the area of injection.

   (Initials_____)

3. Hygiene and cleanings: I understand that the long term success of any dental treatment and status of my oral condition depends on my efforts at proper oral hygiene (i.e brushing and flossing) and maintaining regular recall interval visits as recommended by the doctor or hygienist.

   (Initials_____)

4. Periodontal Treatment: I understand that if I have a condition causing gum inflammation and/or bone loss, which can lead to the loss of my teeth, alternative treatment plans will be explained to me, including non-surgical “deep cleaning”, gum surgery, and/or extractions. I understand that the success of any treatment plan depends in part on my efforts to brush and floss daily, receive regular cleanings as directed, follow a healthy diet, avoid tobacco products, and follow other recommendations as received.

   (Initials_____)

5. Fillings: I understand that sensitivity to cold is common following the placement of a new filling and usually passes within one to two weeks. It has been explained to me that, in very few cases, teeth receiving any type or restorative dental treatment may require the need for root canal treatment. The need for root canal treatment cannot always be predicted and involves an additional fee. The advantages and disadvantages of different filling materials has been explained to me.

   (Initials_____)

6. Crowns, Bridges, Onlays, Inlays, Veneers, and Bonding: I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth or filling material. I further understand that I may be wearing temporary crowns, which may come off, 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 to my new crown, bridge, or other restoration will be prior to cementation. It has been explained to me that, in very few cases, dental procedures may result in the need for future root canal treatment, which cannot always be anticipated. I understand that cosmetic procedures require excellent oral hygiene to prevent recurrent decay and periodontal disease (bone loss).

   (Initials_____)

I understand that dentistry is not an exact science, and therefore, that reputable, ethical practitioners cannot 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 realize that my treatment plan is an estimate and can change due to unforeseen circumstances. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me.

Name (printed) _____

Signature _____ Date _____

Staff Signature _____ Date _____