AHDA

Anaheim Hills Dental Arts

Welcome To Our Office

The mission of our office is to provide a full range of quality dental care with a commitment to excellence and patient education through communication in a caring environment.

Patient Information Packet

Please Complete The Following Pages

To ensure quality patient care we ask that you update this packet every year.

Outline of Procedures for New Patients:

- ☑ The First Appointment is a Examination and Consultation Appointment. At this appointment you can expect to get acquainted with the Doctor and Staff, discuss your medical and dental history, have the Dentist, Hygienist and/or Assistant thoroughly examine your teeth and mouth, and take any necessary x-rays. You will also have a consultation to discuss your comprehensive dental treatment plan based on information from your examination and x-rays. You will also discuss financial arrangements and insurance options with the Treatment Coordinator

- ☑ The Second Appointment is Treatment. During this appointment your restorative and preventative treatment begins.

PATIENT CONFIDENTIAL INFORMATION

Name:_____
First Middle Last

Address:_____
Street City State Zip Code

Home Phone:_____ Work Ph:_____ Cell Ph:_____

Age:_____ Date of Birth:_____ Sex: [Male] [Female] Marital Status: M S D W

Social Security No:_____ CA Driver's License No:_____

Occupation:_____ Employer:_____ How Long?_____

Employer Address:_____
Street City State Zip Code

In case of emergency, call:_____
Name Phone No w/ Area Code

E-Mail Address:_____ Referred to this office by:_____

SPOUSE INFORMATION

Spouse Name:_____
First Middle Last

Date of Birth:_____ Social Security Number:_____

CA Driver's License No:_____ Employer:_____

Employer Address:_____
Street City State Zip Code

Occupation:_____ How Long?_____ Business Phone:_____

PARENT OR GUARDIAN INFORMATION (Complete This Section For Minor Patients)

Father Name:_____
First Middle Last

Address:_____ Home Phone:_____
Street City State Zip Code

Mother Name:_____
First Middle Last

Address:_____ Home Phone:_____
Street City State Zip Code

Child's School Name:_____

AUTHORIZATION TO CONTACT

I authorize AHDA to contact me to confirm my appointment or discuss dental treatment at the following numbers:

Home Phone:	[] AHDA CAN contact me at this number	[] AHDA CANNOT contact me at this number
Work Phone:	[] AHDA CAN contact me at this number	[] AHDA CANNOT contact me at this number
Cell Phone:	[] AHDA CAN contact me at this number	[] AHDA CANNOT contact me at this number

Spouse's Work: [] AHDA CAN contact me at this number [] AHDA CANNOT contact me at this number
Parent's Home: [] AHDA CAN contact me at this number [] AHDA CANNOT contact me at this number

FINANCIAL ARRANGEMENTS

How do you plan to handle your account? [] Cash [] Check [] Credit Card [] Dental Credit Funding*

Please Note: ***Fees are due when services are rendered unless prior arrangements have been made.***

INSURANCE INFORMATION

Dental Insurance Company (primary): _____
Name Address

Insured Person's Name | Birthdate | Relationship | Social Security No.

Employer | Effective Date | Group No. | Plan No. | Union Name | Local

Dental Insurance Company (secondary): _____
Name Address

Insured Person's Name | Birthdate | Relationship | Social Security No.

Employer | Effective Date | Group No. | Plan No. | Union Name | Local

HEALTH HISTORY

Below is a list of conditions which may seem unrelated to the purpose of your dental appointment. However, these questions must be answered carefully as these problems can effect your overall dental diagnosis, treatment plan and the possibility of being accepted for dental care.

MEDICAL HISTORY

1. Are you in good health?..... Yes No
2. Date of last physical examination:_____
3. Are you now under the care of a physician?..... Yes No
   If so, what is the condition being treated?_____
   Physician's Name & Phone Number:_____
4. Have you ever had any serious illness or operation?..... Yes No
   If so, what illness or operation?_____
5. Have you ever been hospitalized?..... Yes No
6. Are you taking any medicine? [] Yes [] No Or any recreational drugs (marijuana, cocaine, etc.) Yes No
   If so, what and what dosage?_____
7. Have you ever been pre-medicated with antibiotics for dental treatment?..... Yes No
   If so, why?_____
8. Are you sensitive or allergic to any drugs? (check if yes) [] Penicillin; [] Tetracycline; [] Sulfa Drugs; [] Aspirin; [] Codeine; [] Latex; [] Nickel; [] Other: _____
9. Do you have or have you had any of the following: (check all boxes, even if the answer is 'No')

* For further information on Dental Credit Funding, please see the receptionist.

Anemia	[] Yes	[] No	Drug Addiction	[] Yes	[] No	AIDS Related Complex	[] Yes	[] No
Asthma	[] Yes	[] No	Kidney Disease	[] Yes	[] No	Excessive Bleeding	[] Yes	[] No
Herpes	[] Yes	[] No	Stomach Ulcers	[] Yes	[] No	Cortisone Medicine	[] Yes	[] No
Stroke	[] Yes	[] No	Emphysema	[] Yes	[] No	Joint Replacement	[] Yes	[] No
Ulcers	[] Yes	[] No	Angina Pectoris	[] Yes	[] No	I have read these questions.	[] Yes	[] No
Diabetes	[] Yes	[] No	Mental Disorder	[] Yes	[] No	Blood Transfusion	[] Yes	[] No
Glaucoma	[] Yes	[] No	Nervous Disorder	[] Yes	[] No	Respiratory Disease	[] Yes	[] No
Arthritis	[] Yes	[] No	Rheumatic Fever	[] Yes	[] No	Sickle Cell Disorder	[] Yes	[] No
Hay Fever	[] Yes	[] No	Thyroid Disease	[] Yes	[] No	Tuberculosis (T.B.)	[] Yes	[] No
Tonsillitis	[] Yes	[] No	Cerebral Palsy	[] Yes	[] No	Epilepsy / Seizures	[] Yes	[] No
Cold Sores	[] Yes	[] No	Tumor or Growth	[] Yes	[] No	Difficulty Swallowing	[] Yes	[] No
Hemophilia	[] Yes	[] No	Cobalt Treatment	[] Yes	[] No	Congenital Heart Lesions	[] Yes	[] No
Rheumatism	[] Yes	[] No	Chemotherapy	[] Yes	[] No	Psychiatric Treatment	[] Yes	[] No
Heart Murmur	[] Yes	[] No	Cancer/Leukemia	[] Yes	[] No	Hypothyroid / Hyperthyroid	[] Yes	[] No
Bruise Easily	[] Yes	[] No	Radiation Treatment	[] Yes	[] No	Heart Ailments	[] Yes	[] No
Head Injuries	[] Yes	[] No	Allergies / Hives	[] Yes	[] No	Heart Attack	[] Yes	[] No
Heart Failure	[] Yes	[] No	Pain in Jaw Joints	[] Yes	[] No	Fainting Spells	[] Yes	[] No
Liver Disease	[] Yes	[] No	TMJ Problems / Pain	[] Yes	[] No	High Blood Pressure	[] Yes	[] No
Scarlet Fever	[] Yes	[] No	Hepatitis	[] Yes	[] No	Low Blood Pressure	[] Yes	[] No
Chicken Pox	[] Yes	[] No	Jaundice	[] Yes	[] No	[] Other:_____		
Sinus Trouble	[] Yes	[] No	Venereal Disease	[] Yes	[] No	_____		
Blood Disease	[] Yes	[] No	AIDS	[] Yes	[] No			

10. Do you wear a cardiac pacemaker, or have you had heart surgery?..... Yes No
11. Do you have any disease, condition or problem not listed that you think the Doctor should know about?..... Yes No
    If so, what?_____
12. Do you smoke? If yes, how much per day?_____
13. (Women) Are you pregnant? [] Yes, how many months?_____ [] No
14. (Women) Do you have any problems associated with your menstrual period?..... Yes No
15. (Women) Do you take birth control pills?..... Yes No
16. Have you ever taken phen-phen?..... Yes No

DENTAL HISTORY

Reason for this visit:_____

Previous Dentist Name:_____ Date of last dental treatment:_____

Are you experiencing pain at this time? [] Yes [] No Any prior major dental treatment? If yes, when?_____

Are you dissatisfied with the appearance of your teeth? [] Yes, why?_____ [] No

Do you have, or do you use any of the following? (check all boxes, even if the answer is 'No')

Teeth sensitive to cold, hot, sweets, pressure.	[] Yes	[] No	Complications from dental extractions.	[] Yes	[] No
Bleeding gums. How long?_____			Periodontal treatment.	[] Yes	[] No
Food impaction.	[] Yes	[] No	Orthodontic treatment.	[] Yes	[] No
Clenching or grinding.	[] Yes	[] No	Oral habits (fingernail biting, lip biting, etc).	[] Yes	[] No
Burning of tongue.	[] Yes	[] No	Mouth breathing.	[] Yes	[] No
Swelling or lumps in mouth.	[] Yes	[] No	Cigarette, Pipe, Cigar Smoking.	[] Yes	[] No
Frequent blisters on lips or mouth.	[] Yes	[] No	Texture of toothbrush:_____		
Pain in or around ear.	[] Yes	[] No	Frequency of brushing:_____		
Unusual sounds in ear while eating.	[] Yes	[] No	Use dental floss.	[] Yes	[] No
Bad breath.	[] Yes	[] No	Use inter dental stimulants.	[] Yes	[] No
I have read each of these questions.	[] Yes	[] No	Use a water jet devise	[] Yes	[] No
Unpleasant taste.	[] Yes	[] No	Use disclosing tablets or solution	[] Yes	[] No
Unfavorable dental experience.	[] Yes	[] No	Use fluoride supplements	[] Yes	[] No

Is there anything else about dental treatment that bothers you?_____

I am seeking the following: [] Relief Care [] Limited Care [] Cosmetic Care [] Long Term Preventative Care

Consent For Treatment. *I hereby authorize the dentist(s) and the AHDA Staff to perform treatment as deemed necessary for the above referenced patient. I have been informed of all possible complications for procedures, anesthetics x-rays.*

All services rendered are accepted under the terms and conditions printed on this Patient Information Packet.

Signature:_____ Date:_____

Relationship to the patient:_____

TERMS & CONDITIONS

As a condition of treatment I understand that payment is due at the time services are rendered and any financial arrangements must be made in advance. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry dental insurance, I understand that this office will, as a courtesy to me, prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. I understand that the entire balance is my responsibility, even if the insurance company does not pay. I will assume financial responsibility for any unpaid balance remaining after the insurance company has considered my claim.

Assignment of Insurance Benefits. I hereby authorize my insurance company to pay directly to my dentist any benefits accrued to me under my policy.

Unpaid Balances. A service charge of 1 ½% per month (18% per annum – in no event shall this rate be more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts no paid within 60 days of the treatment date.

Treatment Estimate. I understand that the treatment plan estimate for my dental treatment can only be extended for a period of three months from the date of the patient's examination. I further understand that this is an estimate, the actual patient portion may be higher.

If my account is forwarded to a collection agency I agree to pay all collection costs. I further agree that in the event that either this office or I institute legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees.

I grant permission to this office, Dentist, assignee, and office staff to telephone me at the numbers listed above to discuss matters related to treatment.

I have read and understand the conditions and treatment and agree to their content.

Patient or Guardian Signature:_____ Date:_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or if my medications change, I will, without fail, inform this office at my next appointment.

Signature:_____ Date:_____

Cancellation Policy: *Anaheim Hills Dental Arts specifically reserves and schedules time to diagnose and treat my dental needs. If I need to cancel, or reschedule, my appointment I will provide this office with at least 24 hours notice. For appointments that are either cancelled or rescheduled with less than 24 hour notice, I understand that I will be charged, and I agree to pay, a $50 missed appointment fee.*

Signature:_____ Date:_____

To keep our records current we will ask you at each visit during the year to update the information contained in this packet. Once per year, you will be asked to complete a new packet.

1st Visit:
Changes in Health:_____

Signature:_____ Date:_____

2nd Visit:
Changes in Health:_____

Signature:_____ Date:_____

3rd Visit:
Changes in Health:_____

Signature:_____ Date:_____

OFFICE USE ONLY – DO NOT WRITE IN THIS SECTION

MEDICAL HISTORY SUMMARY as of date:_____, reviewed by:_____:

Existing Illnesses:_____

Current Drugs:_____

Allergies:_____

Nutritional Evaluation:_____

DENTAL HISTORY SUMMARY as of date:_____, reviewed by:_____:

Chief Complaint:_____

Oral Habits:_____

Hygiene:_____

BEHAVIORAL RESUME as of date:_____, reviewed by:_____:

_____

_____

ASA STATUS:
[] ASA Class 1
[] ASA Class 2
[] ASA Class 3
[] ASA Class 4