

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: _____

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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: _____

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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: _____

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AUTHORIZATION TO CONTACT

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

Home Phone:	<input type="checkbox"/> AHDA CAN contact me at this number	<input type="checkbox"/> AHDA CANNOT contact me at this number
Work Phone:	<input type="checkbox"/> AHDA CAN contact me at this number	<input type="checkbox"/> AHDA CANNOT contact me at this number
Cell Phone:	<input type="checkbox"/> AHDA CAN contact me at this number	<input type="checkbox"/> AHDA CANNOT contact me at this number

Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	AIDS Related Complex	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No
Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Angina Pectoris	<input type="checkbox"/> Yes <input type="checkbox"/> No	I have read these questions.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mental Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis (T.B.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cerebral Palsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy / Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cold Sores	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or Growth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty Swallowing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cobalt Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer/Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypothyroid / Hyperthyroid	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Ailments	<input type="checkbox"/> Yes <input type="checkbox"/> No
Head Injuries	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies / Hives	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in Jaw Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No
Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	TMJ Problems / Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Other: _____	
Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Complications from dental extractions.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums. How long? _____		Periodontal treatment.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Food impaction.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clenching or grinding.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Oral habits (fingernail biting, lip biting, etc).	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning of tongue.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Swelling or lumps in mouth.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cigarette, Pipe, Cigar Smoking.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent blisters on lips or mouth.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Texture of toothbrush: _____	
Pain in or around ear.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequency of brushing: _____	
Unusual sounds in ear while eating.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Use dental floss.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Use inter dental stimulants.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I have read each of these questions.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Use a water jet devise	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unpleasant taste.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Use disclosing tablets or solution	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unfavorable dental experience.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Use fluoride supplements	<input type="checkbox"/> Yes <input type="checkbox"/> 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