# Oceanside Dental Excellence

Dear Valued New Patient:

Welcome to LaCosta Dental Excellence! Thank you for the opportunity to be of service to you and for placing your trust and confidence in our dental team. At LaCosta Dental Excellence, Dr. Stephen Dankworth and Dr. Kimberly Corrigan-Dankworth along with our experienced, friendly and professional staff are genuinely interested in you and are committed to taking the time to get to know you personally, and discuss your concerns, fears and expectations.

Our practice offers the benefit of the latest technologies and state-of-the-art equipment that will make your visit comfortable and help you become an interactive and educated partner in your dental care. The doctors use magnified glasses that allow them to detect even the smallest cavity or cracked tooth. Digital imaging produces digital x-rays and magnified color pictures of your teeth allowing you to see what the doctor is diagnosing. Comfortable chairs, blankets, and headphones are available and the highest standards of infection control are strictly enforced. The doctors and staff are constantly enhancing and advancing their technical skills, training, and education to provide patients with the highest level of quality care.

This introductory packet provides important information to help you make informed decisions about your dental care, and also gives us the information needed to provide you with the best possible dental health services. Please read the information provided and let us know if you have any questions when you come in for your first appointment.

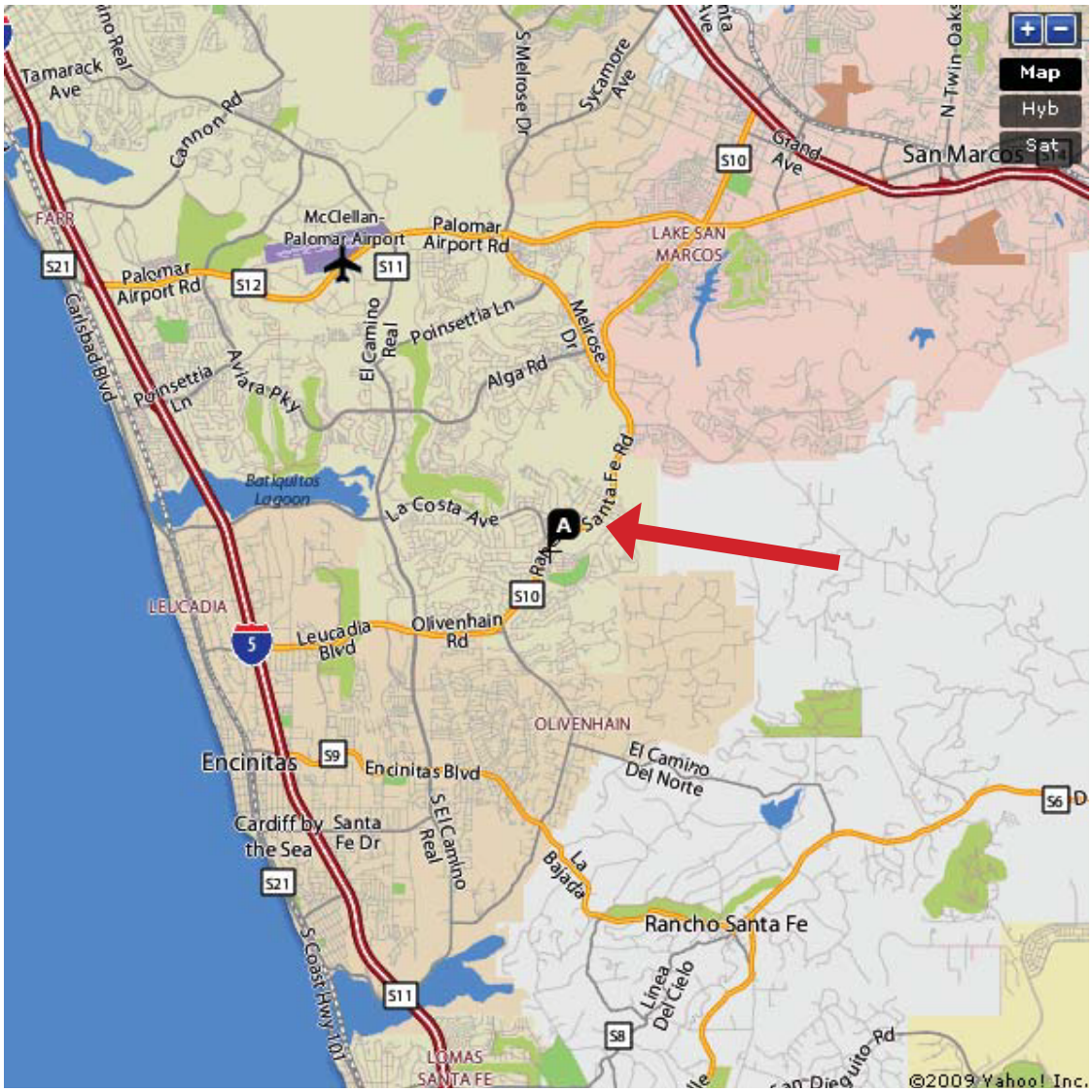
**To save you time at your first appointment, please print pages 9 through 16 and take a moment to fill out the required signature and information sheets before your visit. Please bring the completed pages with you so our staff and the doctor can review your information prior to meeting with you.**

All of us at LaCosta Dental Excellence look forward to providing you with outstanding dental health services.

Sincerely,

Stephen Dankworth, DDS
Kimberly Corrigan-Dankworth, DDS

# Driving Directions to LaCosta Dental Excellence




**From San Diego (5 North):**
Take 5 North. Exit LaCosta Avenue turn right (east) continue past El Camino Real. Cross over Rancho Santa Fe Road and the CVS shopping center is on your right. Take an immediate right into the parking lot. Our office is located directly behind CVS, next door to Arezzo Day Spa and Salon.

**From San Diego/Escondido (15 North):**
Take 15 North to 78 west (towards Oceanside). Exit Rancho Santa Fe Road and turn left. Continue south on Rancho Santa Fe Road approximately 6.5 miles to LaCosta Avenue. Turn left on LaCosta Avenue and turn right into the first driveway behind the CVS shopping Center. We are next door to Arezzo Day Spa and Salon.

**Or:**

From 78 west take 5 south (to San Diego) exit LaCosta Avenue turn east (left) and continue on LaCosta Avenue past El Camino Real and Rancho Santa Fe Road and turn into the first driveway behind the CVS shopping center. We are next door to Arezzo Day Spa and Salon.

**From Los Angeles (5 South):**
Take 5 South; exit LaCosta Avenue turn left (east) continue past El Camino Real heading east. Cross over Rancho Santa Fe Road and you will see a CVS shopping center on your right. Turn into the first driveway behind the CVS shopping center. We are next door to Arezzo Day Spa and Salon.


# Dental Materials Fact Sheet

## What About the Safety of Filling Materials?

Patient health and the safety of dental treatments are the primary goals of California's dental professionals and the Dental Board of California. The purpose of this fact sheet is to provide you with information concerning the risks and benefits of all the dental materials used in the restoration (filling) of teeth.

The Dental Board of California is required by law* to make this dental materials fact sheet available to every licensed dentist in the state of California. Your dentist, in turn, must provide this fact sheet to every new patient and all patients of record only once before beginning any dental filling procedure.

As the patient or parent/guardian, you are strongly encouraged to discuss with your dentist the facts presented concerning the filling materials being considered for your particular treatment.

** Business and Professions Code 1648.10-1648.20*

## Allergic Reactions to Dental Materials

Components in dental fillings may have side effects or cause allergic reactions, just like other materials we may come in contact with in our daily lives. The risks of such reactions are very low for all types of filling materials. Such reactions can be caused by specific components of the filling materials such as mercury, nickel, chromium, and/or beryllium alloys. Usually, an allergy will reveal itself as a skin rash and is easily reversed when the individual is not in contact with the material.

There are no documented cases of allergic reactions to composite resin, glass ionomer, resin ionomer, or porcelain. However, there have been rare allergic responses reported with dental amalgam, porcelain fused to metal, gold alloys, and nickel or cobalt-chrome alloys.

If you suffer from allergies, discuss these potential problems with your dentist before a filling material is chosen.

## Toxicity of Dental Materials

### Dental Amalgam

Mercury in its elemental form is on the State of California's Proposition 65 list of chemicals known to the state to cause reproductive toxicity. Mercury may harm the developing brain of a child or fetus.

Dental amalgam is created by mixing elemental mercury (43-54%) and an alloy powder (46-57%) composed mainly of silver, tin, and copper. This has caused discussion about the risks of mercury in dental amalgam. Such mercury is emitted in minute amounts as vapor. Some concerns have been raised regarding possible toxicity. Scientific research continues on the safety of dental amalgam. According to the Centers for Disease Control and Prevention, there is scant evidence that the health of the vast majority of people with amalgam is compromised.

The Food and Drug Administration (FDA) and other public health organizations have investigated the safety of amalgam used in dental fillings. The conclusion: no valid scientific evidence has shown that amalgams cause harm to patients with dental restorations, except in rare cases of allergy. The World Health Organization reached a similar conclusion stating, "Amalgam restorations are safe and cost effective."

A diversity of opinions exists regarding the safety of dental amalgams. Questions have been raised about its safety in pregnant women, children, and diabetics. However, scientific evidence and research literature in peer-reviewed scientific journals suggest that otherwise healthy women, children, and diabetics are not at an increased risk from dental amalgams in their mouths. The FDA places no restrictions on the use of dental amalgam.

### Composite Resin

Some Composite Resins include Crystalline Silica, which is on the State of California's Proposition 65 list of chemicals known to the state to cause cancer.

It is always a good idea to discuss any dental treatment thoroughly with your dentist.

**The durability of any dental restoration is influenced not only by the material it is made from but also by the dentist's technique when placing the restoration. Other factors include the supporting materials used in the procedure and the patient's cooperation during the procedure. The length of time a restoration will last is dependent upon your dental hygiene, home care, and diet and chewing habits.**

## DENTAL AMALGAM FILLINGS

Dental amalgam is a self-hardening mixture of silver-tin-copper alloy powder and liquid mercury and is sometimes referred to as silver fillings because of its color. It is often used as a filling material and replacement for broken teeth.

**Advantages**

- ❤ Durable; long lasting
- ❤ Wears well; holds up well to the forces of biting
- ❤ Relatively inexpensive
- ❤ Generally completed in one visit
- ❤ Self-sealing; minimal-to-no shrinkage and resists leakage
- ❤ Resistance to further decay is high, but can be difficult to find in early stages
- ❤ Frequency of repair and replacement is low

**Disadvantages**

- Refer to "What About the Safety of Filling Materials"
- Gray colored, not tooth colored
- May darken as it corrodes; may stain teeth over time
- Requires removal of some healthy tooth
- In larger amalgam fillings, the remaining tooth may weaken and fracture
- Because metal can conduct hot and cold temperatures, there may be a temporary sensitivity to hot and cold.
- Contact with other metals may cause occasional, minute electrical flow

## COMPOSITE RESIN FILLINGS

Composite fillings are a mixture of powdered glass and plastic resin, sometimes referred to as white, plastic, or tooth-colored fillings. It is used for fillings, inlays, veneers, partial and complete crowns, or to repair portions of broken teeth.

**Advantages**

- ❤ Strong and durable
- ❤ Tooth colored
- ❤ Single visit for fillings
- ❤ Resists breaking
- ❤ Maximum amount of tooth preserved
- ❤ Small risk of leakage if bonded only to enamel
- ❤ Does not corrode
- ❤ Generally holds up well to the forces of biting depending on product used
- ❤ Resistance to further decay is moderate and easy to find
- ❤ Frequency of repair or replacement is low to moderate

**Disadvantages**

- Refer to "What About the Safety of Filling Materials"
- Moderate occurrence of tooth sensitivity; sensitive to dentist's method of application
- Costs more than dental amalgam
- Material shrinks when hardened and could lead to further decay and/or temperature sensitivity
- Requires more than one visit for inlays, veneers, and crowns
- May wear faster than dental enamel
- May leak over time when bonded beneath the layer of enamel

## PORCELAIN (CERAMIC)

Porcelain is a glass-like material formed into fillings or crowns using models of the prepared teeth. The material is toothcolored and is used in inlays, veneers, crowns and fixed bridges.

**Advantages**

- ❤ Very little tooth needs to be removed for use as a veneer; more tooth needs to be removed for a crown because its strength is related to its bulk (size)
- ❤ Good resistance to further decay if the restoration fits well
- ❤ Is resistant to surface wear but can cause some wear on opposing teeth
- ❤ Resists leakage because it can be shaped for a very accurate fit
- ❤ The material does not cause tooth sensitivity

**Disadvantages**

- Material is brittle and can break under biting forces
- May not be recommended for molar teeth
- Higher cost because it requires at least two office visits and laboratory services

## NICKEL OR COBALTCHROME ALLOYS

Nickel or cobalt-chrome alloys are mixtures of nickel and chromium. They are a dark silver metal color and are used for crowns and fixed bridges and most partial denture frameworks.

**Advantages**

- ❤ Good resistance to further decay if the restoration fits well
- ❤ Excellent durability; does not fracture under stress
- ❤ Does not corrode in the mouth
- ❤ Minimal amount of tooth needs to be removed
- ❤ Resists leakage because it can be shaped for a very accurate fit

**Disadvantages**

- Is not tooth colored; alloy is a dark silver metal color
- Conducts heat and cold; may irritate sensitive teeth
- Can be abrasive to opposing teeth
- High cost; requires at least two office visits and laboratory services
- Slightly higher wear to opposing teeth

## GLASS IONOMER CEMENT

Glass ionomer cement is a self-hardening mixture of glass and organic acid. It is tooth-colored and varies in translucency. Glass ionomer is usually used for small fillings, cementing metal and porcelain/metal crowns, liners, and temporary restorations.

**Advantages**

- ❤ Reasonably good esthetics
- ❤ May provide some help against decay because it releases fluoride
- ❤ Minimal amount of tooth needs to be removed and it bonds well to both the enamel and the dentin beneath the enamel
- ❤ Material has low incidence of producing tooth sensitivity
- ❤ Usually completed in one dental visit

**Disadvantages**

- Cost is very similar to composite resin (which costs more than amalgam)
- Limited use because it is not recommended for biting surfaces in permanent teeth
- As it ages, this material may become rough and could increase the accumulation of plaque and chance of periodontal disease
- Does not wear well; tends to crack over time and can be dislodged

## RESIN-IONOMER CEMENT

Resin ionomer cement is a mixture of glass and resin polymer and organic acid that hardens with exposure to a blue light used in the dental office. It is tooth colored but more translucent than glass ionomer cement. It is most often used for small fillings, cementing metal and porcelain metal crowns and liners.

**Advantages**

- ❤ Very good esthetics
- ❤ May provide some help against decay because it releases fluoride
- ❤ Minimal amount of tooth needs to be removed and it bonds well to both the enamel and the dentin beneath the enamel
- ❤ Good for non-biting surfaces
- ❤ May be used for short-term primary teeth restorations
- ❤ May hold up better than glass ionomer but not as well as composite
- ❤ Good resistance to leakage
- ❤ Material has low incidence of producing tooth sensitivity
- ❤ Usually completed in one dental visit

**Disadvantages**

- Cost is very similar to composite resin (which costs more than amalgam)
- Limited use because it is not recommended to restore the biting surfaces of adults
- Wears faster than composite and amalgam

## PORCELAIN FUSED TO METAL

This type of porcelain is a glasslike material that is "enameled" on top of metal shells. It is toothcolored and is used for crowns and fixed bridges.

**Advantages**

- ❤ Good resistance to further decay if the restoration fits well
- ❤ Very durable, due to metal substructure
- ❤ The material does not cause tooth sensitivity
- ❤ Resists leakage because it can be shaped for a very accurate fit

**Disadvantages**

- More tooth must be removed (than for porcelain) for the metal substructure
- Higher cost because it requires at least two office visits and laboratory services

## GOLD ALLOY

Gold alloy is a gold-colored mixture of gold, copper, and other metals and is used mainly for crowns and fixed bridges and some partial denture frameworks.

**Advantages**

- ❤ Good resistance to further decay if the restoration fits well
- ❤ Excellent durability; does not fracture under stress
- ❤ Does not corrode in the mouth
- ❤ Minimal amount of tooth needs to be removed
- ❤ Wears well; does not cause excessive wear to opposing teeth
- ❤ Resists leakage because it can be shaped for a very accurate fit

**Disadvantages**

- Is not tooth colored; alloy is yellow
- Conducts heat and cold; may irritate sensitive teeth
- High cost; requires at least two office visits and laboratory services

**DENTAL BOARD OF CALIFORNIA**

1432 Howe Avenue • Sacramento, California 95825

www.dbc.ca.gov

Oceanside
Dental Excellence

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# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**
**THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

**OUR LEGAL DUTY**
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 02/03/2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

**USES AND DISCLOSURES OF HEALTH INFORMATION**
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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**PATIENT RIGHTS**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0 for each page, $0 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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**QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

Contact Officer:

Deb Eatros

Telephone: 760-439-3400 Fax: 760-439-5848

Email: Deb@lacostadentalexcellence.com

Address: 3762 Mission Ave, Suite 104, Oceanside, CA 92058

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# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____ SIGN HERE
{Signature}

_____
{Date}

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

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**OFFICE SCHEDULING POLICIES**

To Our Patients:

The following information about our office policies is provided for your understanding. We feel that the more you know about our policies and methods of practice, the more we can be of service to you and avoid possible misunderstandings and frustration.

When making an appointment please realize we design our schedule to offer individualized quality care for you. We need 48 hours (two working days) notice to change an appointment. This advance notice allows us to offer this valuable chair time to another patient who is in need of treatment. We realize that circumstances sometimes prevent our patients from keeping their appointment. Regretfully you will be billed a minimum of $50.00 for the time lost.

I have read the above information.

_____ SIGN HERE _____

Signature Date

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**THE FACTS ABOUT FILLINGS (Dental Board of California Publication)**

I acknowledge I have received a copy of the Dental Materials Fact Sheet dated May 2004, from LaCosta Dental Excellence as required by state law.

_____ SIGN HERE _____

Signature Date

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PLEASE FILL OUT

**PLEASE HANDLE ME WITH CARE!**

Put a check mark in the box next to the statement(s) that concerns you or describes how you feel. Please share this information with us during your dental exam.

- ☐ I gag easily.
- ☐ I feel out of control when I'm lying down on the dental chair.
- ☐ I have not been to the dentist for a long time, and I feel uncomfortable about what you will say about my teeth and my dental hygiene.
- ☐ Pain relief is a top priority for me.
- ☐ I don't like shots for I've had a bad reaction to shots.
- ☐ Please tell me what I need to know about my mouth in order to make an informed decision.
- ☐ My teeth are very sensitive.
- ☐ I don't like the sound of that tool that makes the picking and scraping noise.
- ☐ I don't like cotton in my mouth.
- ☐ I don't like the noise of the drill.
- ☐ Please respect my time. I don't want to be left sitting in the reception area or dental chair.
- ☐ I would prefer to have as much done during my appointments to minimize my visits.
- ☐ I want to know the cost up front. No money surprises please.
- ☐ I have difficulty listening and remembering what I hear while sitting in the dental chair.
- ☐ I have health problems that we need to discuss.

Thank you for taking the time to share your concerns with us. This will give us a better understanding of your individual needs and will make a big difference in how you are treated and how you feel about coming to the dentist.

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PLEASE FILL OUT

**WELCOME!**

"*When it comes to life, the critical thing is whether you take things for granted or take them with gratitude*."

Our new patients are very important to us and we want to know how you heard about us.

Please check off ALL that pertain to you.

NAME: _____

- ☐ Friend name: _____
- ☐ Smilecard from: _____
  Family or Friend (circle one)
- ☐ Internet
- ☐ TV
- ☐ Radio
- ☐ Smile Magazine
- ☐ Smile Postcard
- ☐ Professional name: _____
- ☐ Former patient
- ☐ Location
- ☐ Other: _____

Thank you. We'll never take our patients for granted

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## INFORMATION FOR OUR PATIENTS WITH DENTAL INSURANCE

Since we feel strongly that our patients deserve the best dental care we can provide, and in an effort to maintain a high quality of care, we would like to share some facts about dental insurance with you.

As a courtesy to our patients, we will submit all insurance claims on your behalf and will handle any correspondence that your insurance company may have. We ask that you pay the estimated patient portion at the time of service. If there is any residual after insurance pays, we will send that on to you for final payment. The only exception to this is if you have Delta Dental and Blue Cross. Because they only pay the subscriber (patient) not the provider, we ask that you pay the full amount at the time of service and your insurance will send you the check within 10-14 business days. All insurance companies must be a "preferred provider program" (PPO) in order for us to get reimbursement. However, we are "out-of-network" for all insurance companies.

We submit pre-determinations on a limited basis. Pre-determinations are not a guarantee of payment, only an estimate. Pre-determinations take approximately 4-6 weeks to get a response back. The estimates we are given via fax, telephone or insurance website are just as accurate but again are only an estimate.

We consider our relationship with YOU to be our primary importance and will always make our recommendations to you based on what we believe is the very best treatment for you regardless of your insurance coverage. We hope you understand that your insurance coverage is a contract between you and your insurance company, or between your employer and the insurance company. Therefore, as the patient, it is ultimately your responsibility to deal with your insurance company and/or your employer. We will assist in any way possible to maximize your dental insurance benefits, but to reemphasize; we have no relationship or responsibility to your insurance company.

**FACT #1:** Dental Insurance is not meant to be a "PAY-ALL"; it is only meant to be an aid.

**FACT #2:** Many plans tell their insured that they will be covered "up to 80%" or "up to 100%". In spite of what you're told, we've found many plans cover 40% to 50% of an average fee. Some plans pay more…some pays less. The amount your plan pays is determined by the contribution you and your employer make to your dental plan. The smaller the contribution paid into the plan for "insurance", the less you'll receive. It is your responsibility to advise us of your insurance coverage and restrictions.

**FACT #3:** It has been the experience of many dentists that some insurance companies tell their customers that "fees are above the usual and customary fees" rather than saying to them that "our benefits are low". Remember you get back only what you and your employer put into your insurance coverage less the profits of the insurance company. In dealing with over 1000 dental insurance plans, most plans cover a percentage of our fees.

**FACT #4:** Each plan utilized in our office has different percentages, deductibles, maximums, procedures covered, and varying fees that the plan will allow. We will do our very best to make as close a calculation as possible of what your insurance plan will cover. However, as we cannot estimate precisely, there may be variances for which the patient is individually responsible.

**FACT #5:** Insurance carriers DO NOT cover many routine dental services. We make our recommendations based on your needs and not on what your insurance may or may not cover.

Please do not hesitate to ask us any questions about our office policies. We want you to be comfortable in dealing with these matters and we urge you to consult us if you have any questions regarding our services and/or fees. If you have any questions regarding your insurance, please contact your insurance carrier regarding the specifics and details of the plan they are operating on your behalf.

Signature: SIGN HERE _____ Date: _____

# CONFIDENTIAL INFORMATION QUESTIONNAIRE

| PATIENT'S NAME LAST FIRST MIDDLE | DATE OF BIRTH | SEX | SOCIAL SECURITY # |
|---|---|---|---|
| | | | |

| PATIENT'S ADDRESS STREET APT # CITY STATE ZIP | HOME/CELL PHONE |
|---|---|
| | (H)<br>(C) |

| MARITAL STATUS<br>☐ M ☐ S ☐ D ☐ W<br>☐ UNDER AGE 18 | PATIENT'S/GUARDIAN'S EMPLOYER | OCCUPATION | EMAIL ADDRESS |
|---|---|---|---|
| | | | |

| WORK ADDRESS STREET CITY STATE ZIP | WORK PHONE | OK TO CALL WORK<br>☐ YES ☐ NO |
|---|---|---|
| | | |

| SPOUSE'S NAME LAST FIRST MIDDLE | SPOUSE'S EMPLOYER | OCCUPATION |
|---|---|---|
| | | |

| WORK ADDRESS STREET CITY STATE ZIP | WORK PHONE | OK TO CALL WORK<br>☐ YES ☐ NO |
|---|---|---|
| | | |

| PERSON WE CAN CONTACT IN CASE OF EMERGENCY (OTHER THAN YOUR FAMILY HOME)<br>NAME RELATIONSHIP WORK # HOME # |
|---|
| |

| OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE | WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE? |
|---|---|
| | |

| INSURANCE COVERAGE<br>☐ YES ☐ NO | INSURANCE COMPANY NAME | INSURANCE ADDRESS |
|---|---|---|
| | | |

| SUBSCRIBER'S NAME | PATIENT'S RELATIONSHIP TO SUBSCRIBER<br>☐ SELF ☐ SPOUSE ☐ DEPENDENT | SUBSCRIBER'S DATE OF BIRTH | SUBSCRIBER'S SSN |
|---|---|---|---|
| | | | |

| GROUP/PROGRAM NUMBER | EMPLOYER (IF DIFFERENT FROM ABOVE) | EMPLOYER ADDRESS |
|---|---|---|
| | | |

| SECONDARY COVERAGE<br>☐ YES ☐ NO | INSURANCE COMPANY NAME | INSURANCE ADDRESS |
|---|---|---|
| | | |

| SUBSCRIBER'S NAME | PATIENT'S RELATIONSHIP TO SUBSCRIBER<br>☐ SELF ☐ SPOUSE ☐ DEPENDENT | SUBSCRIBER'S DATE OF BIRTH | SUBSCRIBER'S SSN |
|---|---|---|---|
| | | | |

| GROUP/PROGRAM NUMBER | EMPLOYER (IF DIFFERENT FROM ABOVE) | EMPLOYER ADDRESS |
|---|---|---|
| | | |

**CONSENT**:

1. The undersigned hereby authorizes doctor to take X-rays, study models, photographs, or other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that all +1½% finance charge (18% APR) may be added to my account in addition to any collection charges.
4. I understand that, where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient _____ SIGN HERE Date _____

Parent or Responsible Party _____ Relationship to Patient _____

FOR OFFICE USE: _____ DATE _____

# MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician _____

Most recent physical examination date _____ Purpose _____

What is your estimate of your general health? Poor _____ Fair _____ Good _____

| HAVE YOU EVER HAD THE FOLLOWING: | YES | NO |
|---|---|---|
| 1. hospitalization for illness or injury | ❑ | ❑ |
| 2. allergic reaction to: | | |
| ❑ aspirin | | |
| ❑ penicillin | | |
| ❑ erythromycin | | |
| ❑ tetracycline | | |
| ❑ codeine | | |
| ❑ local anesthetic | | |
| ❑ flouride | | |
| ❑ metals (gold, stainless steel) | | |
| ❑ latex | | |
| ❑ any other medications _____ | | |
| 3. heart problems | ❑ | ❑ |
| 4. heart murmur | ❑ | ❑ |
| 5. rheumatic fever | ❑ | ❑ |
| 6. scarlet fever | ❑ | ❑ |
| 7. high blood pressure | ❑ | ❑ |
| 8. low blood pressure | ❑ | ❑ |
| 9. a stroke | ❑ | ❑ |
| 10. artificial prosthesis (i.e. heart valve or joints) | ❑ | ❑ |
| 11. anemia or other blood disorder | ❑ | ❑ |
| 12. prolonged bleeding due to a slight cut | ❑ | ❑ |
| 13. emphysema | ❑ | ❑ |
| 14. tuberculosis | ❑ | ❑ |
| 15. asthma | ❑ | ❑ |
| 16. sinus problems | ❑ | ❑ |
| 17. kidney disease | ❑ | ❑ |
| 18. liver disease | ❑ | ❑ |
| 19. jaundice | ❑ | ❑ |
| 20. thyroid or parathyroid disease | ❑ | ❑ |
| 21. hormone deficiency | ❑ | ❑ |
| 22. high cholesterol | ❑ | ❑ |
| 23. diabetes | ❑ | ❑ |
| 24. stomach or duodenal ulcers | ❑ | ❑ |
| 25. digestive disorders | ❑ | ❑ |
| 26. arthritis | ❑ | ❑ |
| 27. glaucoma | ❑ | ❑ |
| 28. contact lenses | ❑ | ❑ |
| 29. head or neck injuries | ❑ | ❑ |
| 30. epilepsy, convulsions (seizures) | ❑ | ❑ |
| 31. viral infections and cold sores | ❑ | ❑ |
| 32. any lumps or swelling in the mouth | ❑ | ❑ |
| 33. hives, skin rash, hay fever | ❑ | ❑ |
| 34. venereal disease | ❑ | ❑ |
| 35. hepatitis (type _____) | ❑ | ❑ |
| 36. HIV / AIDS | ❑ | ❑ |
| 37. tumor, abnormal growth | ❑ | ❑ |
| 38. radiation therapy | ❑ | ❑ |
| 39. chemotherapy | ❑ | ❑ |
| 40. emotional problems | ❑ | ❑ |
| 41. psychiatric treatment | ❑ | ❑ |
| 42. antidepressant medication | ❑ | ❑ |
| 43. alcohol / drug dependency | ❑ | ❑ |
| **ARE YOU:** | | |
| 44. presently being treated for any illness | ❑ | ❑ |
| 45. aware of a change in your general health | ❑ | ❑ |
| 46. often exhausted or fatigued | ❑ | ❑ |
| 47. subject to frequent headaches | ❑ | ❑ |
| 48. a heavy smoker (1 pack or more a day) | ❑ | ❑ |
| 49. considered a touchy person | ❑ | ❑ |
| 50. often unhappy or depressed | ❑ | ❑ |
| 51. easily upset or irritated | ❑ | ❑ |
| 52. FEMALE - taking birth control pills | ❑ | ❑ |
| 53. FEMALE - pregnant | ❑ | ❑ |
| 54. MALE - prostate disorders | ❑ | ❑ |

Please describe any current medical treatment, impending surgery, or other treatment that my possibly affect your dental treatment _____

_____

_____

List any medications, herbal supplements, and/or vitamins taken within the past two years _____

_____

_____

**PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING**

Patient's Signature 

Date _____

Doctor's Remarks: _____

_____ Doctor's Signature _____

# DENTAL HISTORY

Referred by _____

Previous dentist _____ How long _____

Most recent dental exam _____ Most recent dental x-ray _____

Most recent dental treatment _____

How often do you have your teeth cleaned? 3 mo. _____ 4 mo. _____ 6 mo. _____ 1 year or longer _____

**WHAT IS YOUR IMMEDIATE DENTAL CONCERN?** _____

**PLEASE ANSWER YES or NO TO THE FOLLOWING:**

| | YES | NO |
|---|---|---|
| 1. unhappy with the appearance of your teeth | ❑ | ❑ |
| 2. unfavorable dental experiences | ❑ | ❑ |
| 3. dental fears | ❑ | ❑ |
| 4. problems with effectiveness or bad reactions to dental anesthetic | ❑ | ❑ |
| 5. orthodontic treatment (braces) when | ❑ | ❑ |
| 6. periodontal (gum) treatment when | ❑ | ❑ |
| 7. bleeding gums | ❑ | ❑ |
| 8. avoiding brushing any part of your mouth | ❑ | ❑ |
| 9. part of your mouth is sensitive to temperature | ❑ | ❑ |
| 10. sore teeth | ❑ | ❑ |
| 11. a burning sensation in your mouth | ❑ | ❑ |
| 12. difficulty swallowing | ❑ | ❑ |
| 13. an unpleasant taste or odor in your mouth | ❑ | ❑ |
| 14. dry mouth, throat, and/or eyes | ❑ | ❑ |
| 15. jaw problems (temporomandibular joint) | ❑ | ❑ |
| 16. difficulty opening your mouth widely | ❑ | ❑ |
| 17. stiff neck muscles | ❑ | ❑ |
| 18. awaken with an awareness of your teeth or jaws | ❑ | ❑ |
| 19. tension headaches | ❑ | ❑ |
| 20. clench or grind your teeth | ❑ | ❑ |
| 21. jaw clicking or popping | ❑ | ❑ |
| 22. lost any teeth | ❑ | ❑ |
| 23. do you sweat or tremble a lot during examination | ❑ | ❑ |
| 24. do strange people or places make you afraid | ❑ | ❑ |

## SUPPLEMENTAL DENTURE HISTORY

If you are wearing a partial or complete artificial denture, please complete the following:

| YES | NO | (Please check Yes or No) |
|---|---|---|
| ❑ | ❑ | Has your present denture been relined? When _____ |
| ❑ | ❑ | Is your present denture a problem? Describe _____ |
| ❑ | ❑ | Satisfied with the appearance? _____ |
| ❑ | ❑ | Satisfied with the comfort? _____ |
| ❑ | ❑ | Satisfied with the chewing ability? _____ |

When did you receive your first partial or complete denture? _____

How long have you worn your present denture? _____

Patient's Signature _____ SIGN HERE Date _____

Doctor's Remarks: _____

_____ Doctor's Signature _____