PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT REGISTRATION

Date			
Last Name	First	M.I.	
Prefers to Be Called By			
Address	City	Zip	
Home Phone #	Name of School (if student/dependent)		
Cell	Email		
Birthdate	Age	Male	Female
Married	Single	Divorced	Widowed
Social Security #			

Dental Insurance	
Primary Carrier	
Insurance Company	
Group #	
Employer Name	
Insured's Name	
Date of Birth	Relationship to Patient
Insured's ID #	
Insured's Social Security #	
Secondary Carrier	
Insurance Company	
Group #	
Employer Name	
Insured's Name	
Date of Birth	Relationship to Patient
Insured's ID #	
Insured's Social Security #	

Account Information		
Person Financially Responsible for Account		
Name:		
Relationship to Patient	Social Security #	
Address		
City	State:	Zip:
Phone		
You		
Name:		
Occupation		
Employer's Name		
Phone		

Getting to Know You
Is another member of your family or relative a patient at our office?
Name:
Relationship
You Were Referred to Us By
Name:
Person to Contact for Emergency
Name:
Cell Number:
Home Number:
Relationship:

CONFIDENTIAL HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?
   If NO, explain: _____
2. Yes / No Has there been a change in your health within the last year?
   If YES, explain: _____
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain: _____
4. Yes / No Are you being treated by a physician now? If YES, explain: _____
   Date of last medical exam? _____ Reason for exam: _____
5. Yes / No Have you had problems with prior dental treatment?
   If YES, explain: _____
   Date of last dental exam: _____ Name of last treating dentist: _____
6. Yes / No Are you in pain now?
   If YES, explain: _____

II. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Chest pain (angina)	Yes / No Blood in stools	Yes / No Frequent vomiting
Yes / No Fainting spells	Yes / No Diarrhea or constipation	Yes / No Jaundice
Yes / No Recent significant weight loss	Yes / No Frequent urination	Yes / No Dry mouth
Yes / No Fever	Yes / No Difficulty urinating	Yes / No Excessive thirst
Yes / No Night sweats	Yes / No Ringing in ears	Yes / No Difficulty swallowing
Yes / No Persistent cough	Yes / No Headaches	Yes / No Swollen ankles
Yes / No Coughing up blood	Yes / No Dizziness	Yes / No Joint pain or stiffness
Yes / No Bleeding problems	Yes / No Blurred vision	Yes / No Shortness of breath
Yes / No Blood in urine	Yes / No Bruise easily	Yes / No Sinus problems

Other: _____

III. DO YOU HAVE OR EVER HAD ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Heart disease	Yes / No AIDS/HIV	Yes / No Psychiatric care
Yes / No Family history of heart disease	Yes / No Surgeries	Yes / No Osteoporosis
Yes / No Heart attack	Yes / No Hospitalization	Yes / No Thyroid disease
Yes / No Artificial joint	Yes / No Diabetes	Yes / No Asthma
Yes / No Stomach problems or ulcers	Yes / No Family history of diabetes	Yes / No Hepatitis
Yes / No Heart defects	Yes / No Tumors or cancer	Yes / No Sexual transmitted disease
Yes / No Heart murmurs	Yes / No Chemotherapy	Yes / No Herpes
Yes / No Rheumatic fever	Yes / No Radiation	Yes / No Canker or cold sores
Yes / No Skin disease	Yes / No Arthritis, rheumatism	Yes / No Anemia
Yes / No Hardening of arteries	Yes / No Emphysema or other lung disease	Yes / No Liver disease
Yes / No High blood pressure	Yes / No Kidney or bladder disease	Yes / No Eye disease
Yes / No Seizures	Yes / No Stroke	Yes / No Transplants
Yes / No Cosmetic surgery	Yes / No Eating disorders	Yes / No Tuberculosis

Other: _____

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Aspirin	Yes / No Valium or other sedatives	Yes / No Codeine or other narcotics
Yes / No Penicillin or other antibiotics	Yes / No Latex	Yes / No Food
Yes / No Nitrous oxide	Yes / No Local anesthetic	Yes / No Metal

Others: _____

SCRIPPS RANCH
PERIODONTICS & IMPLANTS

OFFICE POLICIES & ASSIGNMENT OF BENEFITS

FINANCIAL POLICY: We are committed to providing you with the highest quality of dental care using only the best materials and technology available. In our process of doing so, we have formulated a financial policy to continue to provide excellent care. Therefore, payment is due at the time the service is provided. Our office accepts cash, personal checks, Mastercard, Visa, and American Express. Financing for larger amounts is also available through Care Credit and The Lending Club.

Returned checks and balances older than 60 days may be subject to collection fees and finance charges.

_____initial

ASSIGNMENT OF BENEFITS AGREEMENT FOR PATIENTS UTILIZING INSURANCE BENEFITS: If you have PPO dental insurance, as a courtesy, we will process your insurance claims on your behalf. Completing insurance forms is a courtesy we extend to you in an effort to save you time. We will provide an estimated co-payment for you which is due at the time services are rendered. The co-payment is only an estimate of charges and may be found to be insufficient after review by your insurance company. Our practice does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.

Our practice will accept an assignment of benefits from your insurance company so that payment may be made directly to our office. It is important to understand, though, that the agreement regarding your dental benefits is between you, your employer, and your insurance company. Our office is not party to that contract. All charges you incur are ultimately your responsibility, regardless of insurance coverage.

By signing this agreement you are assigning your insurance company to make payment directly to our practice.

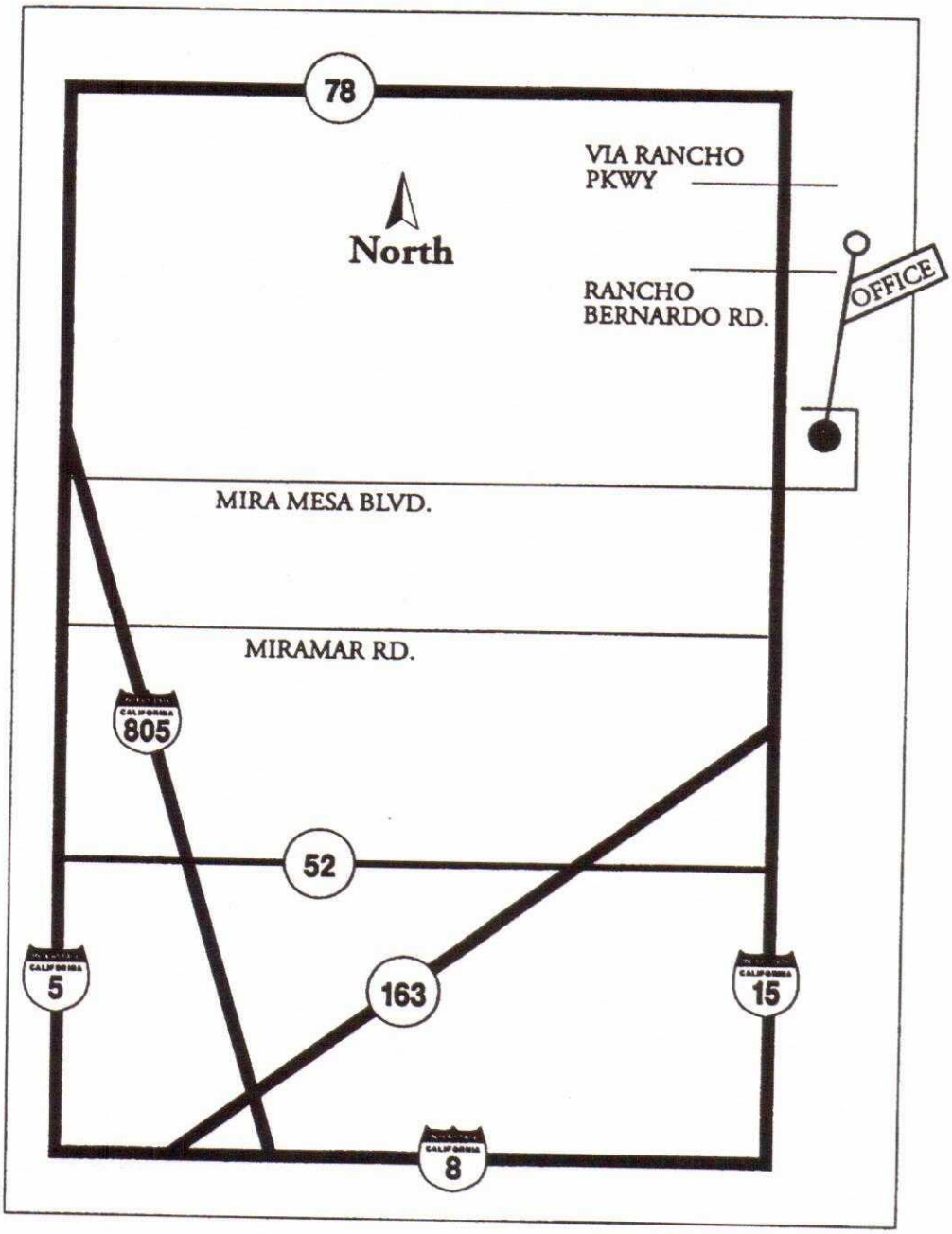
_____initial

APPOINTMENT CHANGE/CANCELLATION POLICY: In order to keep our standard of care at the level necessary to best serve the dental needs of our patients, we ask you to please observe the following guidelines.

1. Appointment availability is limited and the sooner we can schedule your next appointment, the more likely we will find a time which is convenient for you. Periodontal infection tends to increase in bursts of activity and should, therefore, be treated as soon as possible after it has been diagnosed. We will make every effort to provide you with the soonest time possible.
2. Our office will reserve your appointment time solely for you. Other patients will not be scheduled at the same time. Staff and room preparations are also made to accommodate your specific needs.

DIRECTIONS TO OFFICE IN SCRIPPS RANCH:

From INTERSTATE 15, exit at MIRA MESA BLVD. and go east toward the hill. At the stoplight turn left onto SCRIPPS RANCH BLVD. and go uphill one block to ERMA ROAD. Turn left and go downhill to the third driveway at the NORTH COUNTY MEDICAL CENTER, 9855 ERMA ROAD. Our office is near the far end of the building, SUITE 110.



CONSENT FOR TREATMENT

1. I HEREBY AUTHORIZE DOCTOR OR DESIGNATED STAFF TO TAKE X-RAYS, STUDY MODELS, PHOTOGRAPHS, AND OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE BY DOCTOR TO MAKE A THOROUGH DIAGNOSIS OF (NAME OF PATIENT) _____'S DENTAL NEEDS.
2. UPON SUCH DIAGNOSIS, I AUTHORIZE DOCTOR TO PERFORM ALL RECOMMENDED TREATMENT MUTUALLY AGREED UPON BY ME AND TO EMPLOY SUCH AS REQUIRED TO PROVIDE PROPER CARE.
3. I AGREE TO THE USE OF ANESTHETICS, SEDATIVES AND OTHER MEDICATIONS AS NECESSARY. I FULLY UNDERSTAND THAT USING ANESTHEITC AGENTS EMBODIES CERTAIN RISKS. I UNDERSTAND THAT I CAN ASK FOR A COMPLETE RECITAL OF ANY POSSIBLE COMPLICATIONS.
4. I GIVE CONSENT TO THE DOCTOR'S OR DESIGNATED STAFF'S USE AND DISCLOSURE OF ANY ORAL, WRITTEN OR ELECTRONIC HEALTH RECORDS THAT ARE INDIVIDUALLY IDENTIFIABLE AS MINE FOR THE PURPOSE OF CARRYING OUT MY TREATMENT PLAN, PAYMENT AND HEALTH CARE OPERATIONS. I UNDERSTAND THAT ONLY THE MINIMUM AMOUNT OF INFORMATION NECESSARY TO PROVIDE QUALITY CARE WILL BE USED OR DISCLOSED AND THAT A NOTICE FULLY OUTLINING THE PROTECTION OF MY PERSONAL HEALTH INFORMATION IS AVAILABLE.
5. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS. I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.

PATIENT'S SIGNATURE _____

PARENT/RESPONSIBLE PARTY'S SIGNATURE _____

RELATIONSHIP TO PATIENT _____

WITNESS _____

DATE _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please circle Yes or No for each)

Yes / No Recreational drugs	Yes / No Tobacco in any form	Yes / No Antibiotics
Yes / No Over-the-counter medicines	Yes / No Alcohol	Yes / No Supplements
Yes / No Weight loss medications	Yes / No Bisphosphonate (Fosamax)	Yes / No Daily Aspirin

Please list all prescription medications: _____

VI. WOMEN ONLY (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, what month? _____

Yes / No Are you nursing?

Yes / No Are you taking birth control pills?

VII. ALL PATIENTS (Please circle Yes or No for each)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?

Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: _____

Yes / No Have you ever taken Fen-Phen? If YES, when: _____

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

Whom would you like us to contact in case of an emergency?

Name: _____ **Relationship:** _____ **Phone Number:** _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____ _____ _____

Signature of Patient (Parent or Guardian) **Date** **Signature of Dentist** **Date**

MEDICAL UPDATES: **I have reviewed my Health History and confirm that it accurately states past and present conditions.**

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

3. If, for some reason, you must change your appointment, please give us as much advance notice as possible. In this way, we can offer the appointment time to another patient who also has urgent needs.
4. **We require 72 hours advanced notice for hygiene and exam appointment changes.** A $50.00 fee may be assessed per hour of scheduled time for appointments cancelled or changed within 48 hours of the appointment.
5. **We require a $250.00 deposit per hour of scheduled surgery time which is nonrefundable without a one weeks advanced notice for surgery appointment changes.** (deposit will be applied towards your share of cost) If a deposit was not collected a $250.00 fee may be assessed per hour of scheduled time for appointments cancelled or changed within one week of the appointment.

Please note that fees incurred from our change/cancellation policy are not covered by dental insurance and payment is the patient's responsibility.

_____initial

We thank you in advance for your cooperation.

I CERTIFY THAT I HAVE FULLY READ AND ACCEPT THE GUIDELINES AND POLICIES OF THE ABOVE FINANCIAL AND SCHEDULED APPOINTMENT POLICY.

Patient Signature: _____ Date: _____

I HAVE READ AND ACCEPT THE TERMS AND CONDITIONS OF THE ASSIGNMENT OF BENEFITS AGREEMENT. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE PRACTICE.

Patient Signature: _____ Date: _____