Future Dental Care
3752 Florence Street
Redwood City, CA 94063
(650) 780-9429

PATIENT INFORMATION

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? ______

NAME ______ LAST ______ FIRST ______ MIDDLE ______ MARITAL STATUS ______ PREFERRED NAME OR TITLE ______

HOME ADDRESS ______ CITY ______ STATE ______ ZIP ______

HOME PHONE ______ CELL ______ WORK ______

PREFERRED METHOD OF CONTACT: EMAIL ☐ TEXT ☐ PHONE ☐ EMAIL ______

PREVIOUS ADDRESS (IF LESS THAN 3 YEARS) STREET ______ CITY ______ STATE ______ ZIP ______

SOCIAL SECURITY NO. ______ BIRTH DATE ______ DRIVER'S LICENSE NO. ______

EMPLOYER ______ OCCUPATION ______ YEARS EMPLOYED ______

EMPLOYER'S ADDRESS ______ CITY ______ STATE ______ ZIP ______

SPOUSE'S NAME ______ SPOUSE'S BIRTH DATE ______ SOCIAL SECURITY NO. ______

SPOUSE'S EMPLOYER ______ OCCUPATION ______ WORK PHONE ______

EMPLOYER'S ADDRESS ______ CITY ______ STATE ______ ZIP ______

INSURANCE INFORMATION

INSURED'S NAME ______ GROUP/POLICY NO. ______ UNION LOCAL NO. ______

EMPLOYER ______
NAME ADDRESS CITY STATE ZIP

INSURANCE CO. ______
NAME ADDRESS CITY STATE ZIP

DO YOU HAVE DUAL (SECONDARY) COVERAGE? ☐YES ☐No; if yes, please complete the following

INSURED'S NAME ______ GROUP/POLICY NO. ______ UNION LOCAL NO. ______

EMPLOYER ______
NAME ADDRESS CITY STATE ZIP

INSURANCE CO. ______
NAME ADDRESS CITY STATE ZIP

EMERGENCY INFORMATION

Please list (2) people you would like us to contact in case of emergency.

Family member not living with you #1 ______ Phone (__) ______

#2 ______ Phone (__) ______

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Medical History

Please Print Legibly

PATIENT NAME ______________________________

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ○YES ○NO ○N/A ______
Have you ever been hospitalized or had a major operation? ○YES ○NO ○N/A ______
Have you ever had a serious head or neck injury? ○YES ○NO ○N/A ______
Have you ever had any serious illness? ○YES ○NO ○N/A ______
Do you take, or have you taken, Phen-Fen or Redux? ○YES ○NO ○N/A
Are you on a special diet? ○YES ○NO ○N/A
Do you use tobacco? ○YES ○NO ○N/A
Do you use controlled substances? ○YES ○NO ○N/A

Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penecilin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other ______

Do you have, or have you had any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur*	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve*	☐ Drug Addiction	☐ Heart Pace Maker*	☐ Mitral Valve Prolapse*	☐ Stroke
☐ Artificial Joint*	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain In Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Pschiatric Care	☐ Tonsilitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatment	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever*	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Are you taking any medications, pills, or drugs? ○YES ○NO ○N/A ______

Comments: ______________________________

*Conditions may require medication N/A - Not answered by patient

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 LEGAL GUARDIAN DATE

Health History

Name____Date________________________

What is the reason for your visit today?____

Are you satisfied with your teeth's appearance? …………………………………………………………… No Yes

Are you interested in Professional Whitening of your teeth? …………………………………………….. No Yes

Are you interested in straightening of your teeth? ………………………………………………………...…. No Yes

Are you interested in bad breath management techniques? …………………………...............................…… No Yes

Date of: Last Dental Visit____________Last Dental Cleaning__________Last Full Mouth X-Rays __________

What was done at your last dental visit ____

How often do you have dental examinations____________Previous Dentist's Name ______________________

Telephone______________Address____

How often do you brush your teeth______________Do you use electric toothbrush ………………… No Yes

How often do you floss?_______________What other dental aids do you use (toothpick, etc.)_____________

Do you have any dental problems now? ………………………………………………………………………. No Yes

If yes, please describe ____

Do you feel nervous about having dental treatment? …………………………………………………………. No Yes If yes, what is your biggest concern?____

Have you ever had an upsetting dental experience ……………………………………………………….... No Yes

If yes, please describe____

Is there anything else about having dental treatment that you would like us to know? ____________________

What are your hobbies or special interests (sports etc.)____

Are any of your teeth sensitive to:				**Have you ever had**		
● Hot or cold?	No	Yes		● Orthodontic treatment?	No	Yes
● Sweets?	No	Yes		● Oral Surgery?	No	Yes
● Biting or chewing?	No	Yes		● Periodontal (gum) treatment	No	Yes
● Have you noticed any mouth odors or bad tastes	No	Yes		● A bite plate or mouth guard	No	Yes
● Do you frequently get cold sores, blisters or any other oral lesions?	No	Yes		● A serious injury to the mouth or head?	No	Yes
● **Do your gums bleed or hurt?**	No	Yes		**Have you experienced:**		
● Have your parents experienced gum disease or tooth loss?	No	Yes		● Headaches, neckaches or shoulder aches	No	Yes
●Have you noticed any loose teeth or change in your bite	No	Yes		● Sore muscles (neck, shoulders, side of face)	No	Yes

● Does food tend to become caught in between your teeth	No	Yes		● Pain (side of face, joint, ear?)	No	Yes
Do you				● Clicking or popping of the jaw	No	Yes
● Clench or grind teeth while awake or asleep	No	Yes		● Difficulty in chewing on either side of the mouth?	No	Yes
● Bite your lips or cheeks regularly	No	Yes		● Difficulty in opening or closing the mouth?	No	Yes
● Mouth breathe while awake or asleep?	No	Yes		● Have tired jaws especially in the morning?	No	Yes

INSURANCE/ FINANCIAL POLICY

WE ARE COMMITTED TO PROVIDING YOU WITH THE BEST POSSIBLE CARE. IF YOU HAVE DENTAL INSURANCE, WE ARE HAPPY TO HELP YOU RECEIVE YOUR MAXIMUM ALLOWABLE BENEFITS. IN ORDER TO ACHIEVE THESE GOALS, WE NEED YOUR ASSISTANCE AND UNDERSTANDING OF OUR PAYMENT POLICY.

- I understand there are many different insurance carriers and plans that my employer (or spouse's employer) may have chosen to contract with. I understand that my dental office cannot know or be held responsible for all exclusions & restrictions to my plan. If I have questions or concerns regarding my insurance coverage: I may opt to request a preauthorization from my insurance carrier, for diagnosed procedure(s).
- I understand that my dentist may find a procedure dentally necessary, which may not be covered by my insurance policy.
- I understand that my insurance carrier may have negotiated with my employer, a fee schedule different from dental office fee schedule; "Usual & Customary" can vary greatly.
- I understand that my insurance carrier may have been in network with my previous dentist office) but may not be in network with this office.

I have personally read my dental insurance policy, I understand any estimation given by my dental office is approximate, and responsibility for balance of dental services is mine.

Patient's Name (Please Print)____

Patient or Guardian's Signarure ________________________________ Dated ____________

<u>Please note that, unless canceled at least 48 hours in advance, you may be charged a missed appointment fee, please call our office as soon as possible if you need to reschedule.</u>

☐ I agree that deductibles &/or estimated co-pays will be collected on the Date of Service, Upon receipt of all insurance payments towards my account, I may be billed for any remaining residual balance.

☐ I choose to pay full for all my dental services, rendered on the Date(s) of Service, As a courtesy, my dental office will bill my insurance carrier and sign over insurance benefits to be reimbursed directly to me.

Signature__________________________________ Date ________________

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE, do not hesitate to ask us. We are here to help you.

Consent for Internet Communications

(optional - you May Refuse to Sign This Acknowledgement)

I grant my permission to The Dental Suite to upload and store confidential patient information — including account information, appointment information and clinical information — to the secured web site for The Dental Suite. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand The Dental Suite and myself are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that The Dental Suite is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand The Dental Suite is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use The Dental Suite web site with my ID and password. I also agree to immediately notify The Dental Suite of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns. I also understand State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand The Dental Suite will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my patient information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that The Dental Suite has the right to monitor, retrieve, store, upload and use my patient information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand The Dental Suite will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand The Dental Suite CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above regarding the secured uploading of patient information to the web site for The Dental Suite and grant The Dental Suite permission to securely upload my patient information to the web site.

___________________________________ Date:___________e-mail ____________________ Relationship to Patient: ____________

Signature of patient and/or guardian

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CONSENT TO TREAT

I. As a rule, excellent results can be achieved with informed and cooperative patients. While recognizing the benefits of good dental health, you should also be aware that dentistry and anesthesia, like any treatment to the body, have inherent risks and limitations. These risks are rarely great enough to rule out treatment, but they should be considered when deciding whether to have any treatment performed. It is impossible to list every possible risk. This should be considered an incomplete list, and you should ask if you have any questions.

DISCOMFORT AND SWELLING- This may necessitate several days of home recuperation.

INJURY- Surgery may result in damage to adjacent teeth and fillings or other dental work.

INFECTION - This may require additional treatment, and in rare cases, hospitalization and further surgery.

BRUISING- Stretching of the corners of the mouth may occur, with resulting cracking or black and blue areas elsewhere.

OPENING- You may experience restricted mouth opening for several days or weeks, or longer.

NUMBNESS- There may be a loss of function of sensory nerve in the area of surgery resulting in tingling or numbness of the tongue on the operated side, accompanied by a possible alteration of taste perception and speech. This does not happen often and its occurrence is usually unpredictable. If numbness should occur, the symptoms may persist for weeks or months while the nerve returns to normal function. In rare instances, such numbness can be permanent.

TMJ PAINS- Some people are very sensitive to even a slight discrepancy in their bite. These patients may suffer from noise, pain or dysfunction in the joint of the lower jaw. (Near the ear). This may occur during or after treatment.

II. ANESTHESIA- When any anesthetic is injected into the body, there may be soreness, inflammation and bruising in the area of injection. Unfavorable or allergic reactions may also occur. Specifically, the mixing of cocaine with certain local anesthetics has resulted in sudden death.

I have been informed about the risk of anesthesia, and I consent to administration of anesthesia in order to accomplish the proposed treatment.

III. PRECAUTIONS AFTER TREATMENT- Medications, drugs and anesthetics may cause drowsiness and reduce awareness and coordination. The effect can be increased by the use of alcohol or other drugs, combining birth control pills with certain antibiotics have eliminated the effect of the birth control pills.

IV. ADDITIONAL TREATMENT- Unforeseen circumstances may cause the doctor to recommend a form of treatment not previously discussed. If this occurs, the doctor will carefully explain the reasons for the change in the treatment plan and any extra fee before proceeding. If any unforeseen condition should arise during the operation, calling for additional or different procedures, I authorize the doctor to do whatever is advisable in his best judgment.

V. SUCCESS OF TREATMENT- This office intends to do everything possible to provide the best result. However, complete success in every case cannot be guaranteed. Due to individual patient differences, there exists a possibility of failure, relapse, or worsening of the patient condition despite the best of care. Successful treatment will take cooperation from everyone-the doctor, the staff, your family, and most of all, you the patient. Our office thanks you in advance for cooperate in this matter.

The doctor has explained the nature of the specific treatment plan to me, including the risk listed above, the alternatives, and the potential consequences for not having the treatment. I have read and understand the above, including the risk and limitations of anesthesia, the possibility of additional treatment, and the possibility that treatment may not be 100% successful. I consent to treatment on these terms.

Patient's Name (Please Print) ______________________________

Dated: ____________________ Signed: ______________________________

Dated: ____________________ Doctor: ______________________________