Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had or have any of the following? Please circle Yes or No.

YES/NO AIDS
YES/NO Birth Control
YES/NO Anemia
YES/NO Arthritis
YES/NO Artificial Joints
YES/NO Asthma
YES/NO Blood Disease
YES/NO Cancer
YES/NO Diabetes
YES/NO Dizziness
YES/NO Epilepsy
YES/NO Excessive Bleeding
YES/NO Fainting
YES/NO Glaucoma
YES/NO Growths
YES/NO Hay Fever
YES/NO Head Injuries
YES/NO Heart Disease
YES/NO Heart Murmur
YES/NO Hepatitis
YES/NO High Blood Pressure
YES/NO Jaundice
YES/NO Kidney Disease
YES/NO Liver Disease
YES/NO Latex sensitivity/use of Bisphosphonate
YES/NO Mental Disorders
YES/NO Nervous Disorders
YES/NO Pacemaker
YES/NO Pregnancy
Due date:_____
YES/NO Radiation Treatment
YES/NO Respiratory Problems
YES/NO Rheumatic Fever
YES/NO Rheumatism
YES/NO Sinus Problems
YES/NO Stomach Problems
YES/NO Stroke
YES/NO Tuberculosis
YES/NO Tumors
YES/NO Ulcers
YES/NO Venereal Disease
YES/NO Codeine Allergy
YES/NO Penicillin Allergy

List of medications currently taking, including natural medicine. (if more space necessary inform front desk):_____

*****office use only******
Medical changes/conditions
Doctor/Date

- In case of emergency contact the following person:
  Name: _____ Telephone: ( )_____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Search Engine (Google, Bing, etc.) ☐ Facebook ☐ Yellow Pages ☐ Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

X _____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

HOPE FAMILY DENTISTRY 17185 Arrow Blvd Fontana ,CA 92335

Patient's Name: _____ Chart# _____

1. WORK TO BE DONE:
I understand that I am having the following work done Fillings Bridge Crowns/SSC Extractions **EXAM & X-rays**
Root Canals/Pulpotomy Dentures Partials Periodontics cleaning other (Initials) _____

2. DRUGS AND MEDICATIONS:
I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues. Pain, itching, vomiting, and/or anaphalactic shock (severe allergic reaction.) (Initials) _____

3. CHANGES IN TREATMENT PLAN:
I understand that during treatment it may be necessary to change procedures because of conditions found while working or the teeth that were not discovered during examination. I give my permission to the dentist to make those changes as necessary. (Initials) _____

4. REMOVAL OF TEETH:
Alternatives to removal have been explained to me (root canal therapy, crowns and periodontal surgery, etc.) and I authorize the dentist to remove the following teeth: _____, I understand removing teeth does not always remove all the infection. if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, ton and surrounding tissue (parasthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specia or even hospitalizations of complications arise during or following treatment. (Initials) _____

5. ANESTHESIA:
I realize that risks involved in receiving an anesthetic, some of which are " upset stomach, dizziness, vomiting, sore arm, inflamed vessels of the arm, adverse reactions to drugs causing cardiac arrest, miscarriage; dislodging or chipping teeth and jaw bone. (Initials) _____

6. CROWNS, STAINLESS STEEL CROWNS, BRIDGES, CAPS ONLAY:
I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. (Initials) _____

7. DENTURES-COMPLETE OR PARTIAL
I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me including looseness, soreness, and possible breakage, and relining due to tissue change. (Initials) _____

8. ENDODONTIC TREATMENT, RE-TREATMENT, PULPOTOMY:
I realize there is **NO GUARANTEE** that root canal, pulpotomy treatment will save my tooth, and that complications can occur from the treatment, and that occasior metal objects are cemented in the tooth or extend through the root which does not necessarily effect the success of the treatment. (Initials)_____

9. PERIODONTAL LOSS (TISSUE, BONE):
I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth and other complications. The alternati treatment plans have been explained to me, including gum surgery, replacements and/extractions. I also understand that although these treatments have a high degree of success, it cannot be guaranteed. Occasionally, treated teeth may require extraction

10. I have been advised by the dentist that the silver amalgam restoration is an acceptable procedure according to ADA guidelines and, as such, is a treatment used by Hope Family Dentistry. The advantage and advantage of alternative materials has been explained to me. (Initials) _____

I hereby request and authorize the Dentists, and their Staff, to perform dental work upon me for the purpose of attempting to improve my appearance, function health of my mouth, teeth, bone and tissues, as explained above.

The effect and nature of the proceeding to be performed, and risks involved, as well as possible alternative methods of treatment have fully explained to me. I a authorize the operating Dentist and Assistants to perform any other procedure which they may deem necessary or desirable to attempting to improve the condition stated o the diagnostic treatment form or treat unhealthy or unforeseen conditions that my be encountered during the operation.

I know that the priactice of Dentistry and surgery is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the treatment which I have herein requested and authorized

I also understand that is my responsibility to inform the dentist if I am having any problems during or following treatment so as to allow him to help Minimize any problem. (Initials) _____

Alternative and possible untoward reactions have been explained to me in detail and clearly. Complications, such as infection, hemorrhage and/or bleeding, scarring, contraction, possible deformities, prolonged healing time over the estimate reaction to any drugs before. During and after surgery, numbness or itching of the tongue, lip, teeth, tissues (Parasthesia.) fractured jaw etc... have been clearly explained to me. (Initials) _____

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT AND THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE. ANYTHING I DID NOT UNDERSTAND HAS BEEN EXPLAINED TO ME.

SIGNATURE: _____ RELATIONSHIP: _____ DATE: _____
PATIENT OR LEGAL REPRESENTATIVE

DOCTOR: _____ WITNESS: _____

{NAME OF PRACTICE}

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____ Cell Phone( )

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____

HOPE FAMILY DENTISTRY
12716 S. Central Ave
Chino, CA 91710
Tel (909) 628-5133
Fax (909) 628-2636

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____