WELCOME/BIENBENIDO

SONIA DHILLON, DDS
423 NORTH L STREET, LIVERMORE, CA 94551 925-449-7167

PATIENT INFORMATION/*INFORMACIÓN DEL PACIENTE*

First Name/Nombre | Last Name/*Apellido* | Age/*Edad*

Address/*Dirección*

City/*Ciudad* | State/*Estado* | Zip/*Código postal*

Home Phone Number/*Teléfono Particular* | Work Phone Number/ *Teléfono Laboral*

Cell Phone Number/ *Teléfono Cellular* | Email/*Correo Electrónico*

Social Security Number/*Número de Seguro Social* | Date of Birth/*Fecha de Nacimiento*

Emergency Contact Name/*Nombre del Contacto de Emergencia* | Phone Number/ *Teléfono*

Whom may we thank for referring you to our office?/ *quen lo refirió a esta officina?*

POLICY HOLDER/RESPONSIBLE PARTY INFORMATION/*INFORMACIÓN DEL RESPONSABLE/TITULAR DE PÓLIZA*

Name (if other than patient name)/*Nombre (si no es el paciente*) | Relationship to Patient/*Relacion con el Paciente*

Address/*Dirección*

City/*Ciudad* | State/*Estado* | Zip/*Código Postal*

Social Security Number/*Número de Seguro Social* | Policy Holders Date of Birth/*Fecha de Nacimiento del Titular Póliza*

Employer Name/*Nombre del Empleador* | Insurance Company/*Empresa de Seguro*

Union Local/*Sindicato Local* | Group or Policy Number/*Numero de Póliza o Grupo*

DENTAL HISTORY/*ANTECEDENTES DENTALES*

Previous Dentist Name/*Nombre del Dentista Anterior* | Reason for Leaving/*Motivo de Abandono*

Date of Last Cleaning/*Fecha de Última Limpieza*

Explain the reason for your visit today/*Explique el motivo de la visita de hoy*_____

INSURANCE CO_____FEE SCHEDULE_____MEDICAL ALLERTS

DENTAL HISTORY/*ANTECEDENTES DENTALES*

__Y/S __N/N Are you experiencing any discomfort? / *¿Siente alguna molestia?*
__Y/S __N/N Do you snore? / *¿Usted ronca?*
__Y/S __N/N Do you have bleeding gums? / *¿Le sangran las encías?*
__Y/S __N/N Do you have bad breath? / *¿Tiene mal aliento?*
__Y/S __N/N Do you grind your teeth? / *¿Aprieta los dientes?*
__Y/S __N/N Do you play sports? / *¿Practica algún deporte?*
__Y/S __N/N Are you sensitive to hot, cold or sweets? / *¿Tiene sensibilidad al calor, el frio o los dulces?*
__Y/S __N/N Have you ever received periodontal therapy ?/ *¿Ha recibido terapia periodontal alguna vez?*
__Y/S __N/N Do you take fluoride supplements? / *¿Toma suplemento de fluor?*
__Y/S __N/N Do you use tobacco? / *¿Consume tabaco?*
__Y/S __N/N Do you drink coffee or tea? / *¿Bebe café o té?*
__Y/S __N/N Interested in having whiter/brighter teeth? / *¿Le interesaría tener dientes más blancos/brillantes?*
__Y/S __N/N Do you have difficulty brushing your teeth? / *¿Tiene dificultades para cepillarse los dientes?*
How would you rate your smile on a scale from 1 to 10, with 10 being the highest? / *¿Cómo calificaría su sonrisa en una escala de 1 al 10, siendo 10 la calificación más alta?*
_____
__Y/S __N/N Have you ever been in an accident that damaged your teeth? / *¿Alguna vez sufrió un accidente que dañó sus dientes?*
__Y/S __N/N Does your jaw pop or do you hear clicking when chewing? / *¿Tiene la mandibula desplazada hacia adelante o escucha chasquear sus dientes cuando mastica?*

PLEASE CHECK ANY HABITS:/*POR FAVOR MARQUE CUALQUIERA DE ESTOS HÁBITOS:*

☐ Nail biting/*Morderse las uñas*
☐ Lip biting/*Morderse el labio*
☐ Mouth breathing/*Respirar por la boca*
☐ Thumb sucking/*Chuparse el dedo pulgar*
☐ Night grinding/*Rechinar los dientes por la noche*
☐ Pencil biting/*Morder el lápiz*

DENTURES/PARTIAL PATIENTS/*PACIENTES CON PRÓTESIS PARCIALES/DENTADURAS*

__Y/S __N/N Do you wear a denture or partial? / *¿Usa dentadura postiza o prótesis parciales?*
_____ How old is your denture or partial? / *¿Qué antigüedad tiene su dentadura postiza o prótesis parcial?*
__Y/S __N/N Does your denture cause irritations/soreness? / *La dentadura postiza ¿le causa irritación/dólar?*
__Y/S __N/N Are your dentures loose? / *¿Su dentadura postiza esta floja?*

MEDICAL HISTORY/*ANTECEDENTES MÉDICOS*

_____
Primary Care Physician's Name/*Médico de Atención Primaria* Physician Phone Number/*Teléfono del Médico*

__Y/S __N/N Are you under a physician's care? / *¿Se atiende con algún médico?*
__Y/S __N/N Have you ever been hospitalized or had a major operation*? / ¿Alguna vez ha sido hospitalizado o ha sido sometido una intervención quirúrgica importante?*
__Y/S __N/N Have you ever had a serious head or neck injury*? / ¿Ha sufrido alguna vez una lesión de cabeza o cuello grave?*
__Y/S __N/N Women: Are you pregnant, trying to get pregnant or nursing*? / Mujeres: ¿Está embarazada, intentando quedar embarazada o amamantando?*
__Y/S __N/N Do you use controlled substances? / *¿Utiliza sustancias de consumo controlado?*

If you answered yes to any of the above questions, please explain: / S*i respondió si a cualquiera de las preguntas anteriores, por favor explique:*

_____

Are you allergic or do you react adversely to any of the folllowing? / *¿Es usted alérgico o sufre reacciones adversa a alguno de las siguientes elementos?*

__Y/S __N/N Aspirin / *Aspirina*
__Y/S __N/N Acrylic / *Acrilico*
__Y/S __N/N Sulfa drugs / *Fármacos con sulfa*
__Y/S __N/N Penicillin or other antibiotics / *Penicilina u otros antibióticos*
__Y/S __N/N Tetracycline / *Tetraciclina*
__Y/S __N/N Metal / *Metal*
__Y/S __N/N Barbiturates, sedatives or sleeping pills / *Barbitúricos, sedantes u otras píldoras para dormir*
__Y/S __N/N Codeine / *Codeina*
__Y/S __N/N Latex / *Látex*
__Y/S __N/N Local anesthetics (Novacaine-like medications) / *Anestésicos locales (medicamento parecido a la Novacaína)*
__Y/S __N/N Milk protein / *Proteina de la leche*

Other/*Otros*_____

Please check any conditions that you currently or previously have had: /*Marque las condiciones que tenga actualmente o que haya tenido anteriormente:*

- ☐ AIDS/HIV positive/*SIDA/VIH positivo*
- ☐ Alzheimer's Disease/*Enfermedad de Alzheimer*
- ☐ Anaphylaxis/*Anafilaxis*
- ☐ Anemia/*Anemia*
- ☐ Angina/*Angina*
- ☐ Arthritis/Gout/*Artritis/Gota*
- ☐ Artificial Heart Valve*/*Válvula cardíaca artificial**
- ☐ Artificial Joint*/*Articulación artificial**
- ☐ Asthma/*Asma*
- ☐ Blood Disease/*Enfermedad sanguínea*
- ☐ Blood Transfusion/*Transfusión de sangre*
- ☐ Breathing Problem/*Problemas respiratorios*
- ☐ Bruise Easily/*Formación de moretones*
- ☐ Cancer/*Cáncer*
- ☐ Chemotherapy/*Quimioterapia*
- ☐ Chest Pains/*Dolores en el pecho*
- ☐ Cold Sores/Fever Blisters/*Aftas/ampollas*
- ☐ Congenital Heart Disorder/*Trastorno cardíaco congénito*
- ☐ Convulsions/*Convulsiones*
- ☐ Cortisone Medicine/*Medicación con cortisona*
- ☐ Diabetes/*Diabetes*
- ☐ Drug Addiction/*Drogadicción*
- ☐ Easily Winded/*Se agita fácilmente*
- ☐ Emphysema/*Enfisema*
- ☐ Endocarditis/*Endocarditis*
- ☐ Epilepsy or Seizures/*Epilepsia o convulsiones*
- ☐ Excessive Bleeding /*Hemorragia excesiva*
- ☐ Excessive Thirst/*Sed excesiva*
- ☐ FaintinSpells/Dizziness/*Desmayos/mareos*
- ☐ Frequent cough/*Tos frecuente*
- ☐ Frequent Diarrhea/*Diarrea frecuente*
- ☐ Frequent Headaches/*Dolores de cabeza frecuentes*
- ☐ Glaucoma/*Glaucoma*
- ☐ Hay Fever/*Fiebre del heno*
- ☐ Heart Attack/Failure/*Insuficiencia/ataque cardíaco*
- ☐ Heart Murmur*/*Soplo cardíaco**
- ☐ Heart Pacemaker*/*Marcapasos cardíaco**
- ☐ Heart Trouble/Disease/*Problemo cardíaco*
- ☐ Hemophilia/*Hemofilia*
- ☐ Hepatitis A/*Hepatitis A*
- ☐ Hepatitis B or C/*Hepatitis B o C*
- ☐ Herpes/*Herpes*
- ☐ High Blood Pressure/ *Presión arterial elevada*
- ☐ Hives or rash/*Erupciones*
- ☐ Hypoglycemia/*Hipoglucemia*
- ☐ Irregular Heartbeat/*Frecuencia cardíaca irregular*
- ☐ Kidney Problems/*Problemas renales*
- ☐ Leukemia/*Leucemia*
- ☐ Liver Disease/*Enfermedad hepática*
- ☐ Low Blood Pressure/*Presión arterial baja*
- ☐ Lung Disease/*Enfermedad pulmonar*
- ☐ Mitra Valve Prolapse*/*Prolapso de válvula Mitral**
- ☐ Osteoporosis/*Osteoporosis*
- ☐ Pain in Jaw Joints /*Dolor en las Articulaciones Mandibulares*
- ☐ Parathyroid Disease/*Enfermedad paratiroidea*
- ☐ Parkinson's Disease/*Enfermedad de Parkinson's*
- ☐ Pins, Rods, Stints or Shunts/*Pernos, varillas, soportes y desviaciones*
- ☐ Psychiatric Care/*Atención psiquiátrica*
- ☐ Radiation Treatments/*Radioterapia*
- ☐ Recent Weight Loss/*Pérdida de peso reciente*
- ☐ Renal Dialysis/*Diálisis renal*
- ☐ Rheumatic fever/Fiebre Reumática
- ☐ Rheumatism/*Reumatismo*
- ☐ Scarlet Fever/*Escarlatina*
- ☐ Shingles/*Culebrilla*
- ☐ Sickle Cell Disease/*Células falciformes*
- ☐ Sinus Problems/*Problemas en los senos paranasales*
- ☐ Spina Bifida/*Espina bífida*
- ☐ Stomach/Intestinal Disease/*Enfermedad estomacales/intestinales*
- ☐ Stroke/accidente cerebrovascular
- ☐ Swelling of Limbs/Hinchazón de las extremídades
- ☐ Thyroid Disease/*Enfermedad tiroidea*
- ☐ Tonsillitis/*Amigdalitis*
- ☐ Tuberculosis/*Tuberculosis*
- ☐ Tumor or Growths/*Tumores o crecimientos*
- ☐ Ulcers/*Úlceras*
- ☐ Venereal Disease/*Enfermedad venérea*
- ☐ Yellow Jaundice/*Ictericia*
- ☐ None/*Ninguno*

*condition may require medication/*Estas condiciones pueden requerir medicación

List any major illness not listed above: / *Mencione cualquier enfermedad importante que no se haya mencionado anterior mente:*

_____

_____

Please check any medications and/or supplements taken in the past 12 months: / Marque los medicamentos y/o los suplementos que haya tomado en los últimos 12 meses:

- ☐ Antibiotics or sulfa drugs / *Antibióticos o fármacos con sulfa*
- ☐ Tranquilzer / *Tranquilizantes*
- ☐ Aspirin (daily) / Aspirina (diariamente)
- ☐ Insulin or diabetes medications / *Insulina o medicamentos para la diabetes*
- ☐ Herbal supplements / *Suplementos a base de hierbas*
- ☐ High blood pressure medicine / *Medicina para la presión arterial elevada*
- ☐ Heart Medications / *Medicamentos para el corazón*
- ☐ Nitroglycerine / *Nitroglicerina*
- ☐ Anticoagulants (e.g. Coumadin, blood thinners) / *Anticoagulantes (por ej. Coumadin)*
- ☐ Contraceptives / *Píldoras anticonceptivas*
- ☐ Bisphosphonates Used to treat osteoporosis, such as Fosamox, Boniva, Actonel And Zometa / *Bifosfonatos (usados para tratar la osteoporósis, cómo Fosamax, Boniva, Actonel Y Zometa)*
- ☐ Phen-Fen or Redux / *Phen-Fen or Redux*

List all medications/supplements you are currently taking: / *Mencione todos los medicamentos/suplementos que esté tomando actualmnte:*

_____

_____

_____

I have answered all questions to the best of my knowledge . I will notify the dental health provider of any change in my health or medication at each visit.

I authorize the dentista/hygienist to use the necessary local/topical anesthesia to perform my treatment in a safe, effective manner during this visit and any future visits, I understand that my failure to provide information on previous adverse reactions may cause unforeseen negative reactions. I release Dr Sonia Dhillon DDS and Associates of all liability regarding undisclosed medical history information.

He respondido todas las preguntas de la mejor manera posible, Avisare al profesional dental en caso de cualquier cambio en mi salud o medicamento en cada visita.

Autorizo al dentista/higienista a usar el anestesico local/topico necesario para realizar mi tratamiento de forma segura y efectiva durante esta visita y en las visitas futuras. Entiendo que si no propociono información sobre reacciones adversas anteriores es posible que se provoquen reacciones negativas inesperadas. Livero a Dr Sonia Dhillon DDS y Asociados de cualquier responsabilidad sobre la información de antecedentes medicos que no haiya mencionado.

_____ _____

Signature of Patient or Guardian/ *Firma del Paciente o Tutor* **Date**/Fecha

_____

Relationship to patient/ *Relacion con el paciente*

CONSENT FOR SERVICES AND ACKNOWLEDGEMENT OF OFFICE POLICIES

1. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.
2. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
3. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment.
4. 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.
5. As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patient. The costs incurred for their care and financial responsibility on the part of each patient must be determined before treatment.
6. I understand that all responsibility for payment for dental services provided in the office for myself or my dependents is mine, due and payable at the time services are rendered, unless other arrangements have been made. A service charge of 1 ½% per month (18% per annum) on unpaid balances will be charged on all accounts exceeding 90 days.
7. 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. Furthermore, I hereby authorize payment directly to Sonia Dhillon, DDS, of the group insurance benefits otherwise payable to me.
8. I understand it is my responsibility to advise your office of any changes in the information contained on this form. 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 and my dental care.
9. I understand the office requests a 48 hour notification in the event an appointment must be rescheduled and requires a 24 hours notice or a charge may be incurred.
10. I have read the above conditions and agree to their content.

_____ _____ _____

Signature of guarantor of payments and/or patient, parent or guardian | Date | Relationship to patient

SONIA DHILLON, DDS

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT and CONSENT
And
ACKNOWLEDGEMENT OF DENTAL MATERIALS FACT SHEET

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken actions relying on this consent.

I acknowledge I have received a copy of the office's Notice of Privacy Practices and a copy of the Dental Materials Fact Sheet.

X _____

Patient or Parent Signature if patient is a minor | Date | Relationship to patient

423 N. L Street Livermore, CA 94550

(925) 449-7167

Oral Screening Consent Form

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health care to our patients. We are concerned about oral cancer and look for it in every patient.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use arc other major predisposing risk factors but **more than 25% of oral cancer victims have no such lifestyle risk factors.** Oral cancer risk by patient profile is as follows:

Increased risk: *patients ages 18-39*
High risk: *patients age 40 and older; tobacco users (any age, any type within 10 years)*
Highest risk: *patients age 40 and older with lifstyle risk factors (tobacco and/or alcohol use); previous history, of oral cancer*

We have recently incorporated ViziLite Plus into our oral screening standard of care. We find that using ViziLite Plus along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. ViziLite plus is similar to proven early detection procedures for other cancers such as mammography, Pap smear, and PSA. ViziLite Plus is a simple and painless examination that gives the best chance to find any oral abnormalities at the earliest possible stage. Early detection of precancerous tissue can minimize or eliminate tile potentially disfiguring effects of oral cancer and possibly save your life. The ViziLite Plus exam will be offered to you annually.

This enhanced examination is recognized by the American Dental Association code revision committee as CDT-5 procedure code D0431; however, this exam might not he covered by your insurance. The fee for this enhanced examination is $65.00

Yes. I authorize the clinician to perform the ViziLite Plus exam along with the standard oral cancer examination. I accept financial responsibility for this enhanced examination.
Print name: _____
Signature: _____ Date: _____

No. I would prefer not to have the ViziLite Plus exam at this time.
Print name: _____
Signature: _____ Date: _____