Richland Dental Center
Gil Julia DMD

CONTACT INFORMATION

Name:
_____
First Middle Last Preferred Name
Address:_____

City: _____ State: _____Zip: _____

Phone (Home):_____ (Work): _____Ext: _____ Cell:_____

Age: _____ Gender: _Female _Male Family Status: _Single _Married _Widowed

Social Security #: _____ Date of Birth: _____ DL # _____

Email Address:_____

Emergency Contact: _____ Relationship: _____

Emergency Contact Numbers_____

The following is for: __the patient __the person responsible for payment
Employer: _____ Occupation: _____ Phone #:_____

RESPONSIBLE PARTY INFORMATION

Name:
_____
First Middle Last Relationship to Patient
Address:_____

City: _____ State: _____Zip: _____

Phone (Home):_____ (Work): _____Ext: _____ Cell :_____

Social Security #: _____ Date of Birth: _____ DL # _____

GETTING TO KNOW YOU

Whom may we thank for referring you to our practice? _____

__Friend __Relative __Dental Office __Internet __School __Work __Insurance__Other:

Activities_____

Hobbies_____

School(if child)_____Grade_____

INSURANCE INFORMATION

Primary Carrier
Insurance Company: _____

Group Number: _____

Employer's Name:_____
Insured's
Name:_____

Date of Birth: _____ Social Security #: _____ Relationship: _____

Insured's I.D. #: _____ Insured's Social Security #: _____
Secondary Carrier
Insurance Company_____

Group Number: _____

Employer's Name: _____
Insured's
Name:_____

Date of Birth: _____ Social Security #: _____ Relationship: _____

Insured's I.D. #: _____ Insured's Social Security #: _____

DENTAL TREATMENT CONSENT FORM

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 assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary, I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. 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. In the event payments are not received by agreed upon dates, I understand that a 1½ % late charge (18% APR) may be added to my account. If required, I also understand that a check of my credit history may be made.
5. FOR YOUR INFORMATION – PLEASE READ OFFICE POLICY. WE WOULD LIKE YOU TO BE INFORMED ABOUT OUR POLICIES. Please take a few moments to read and acknowledge this:
FIXED OR REMOVAL PROSTHETICS, such as dentures, crowns, bridges, or partial dentures, are understood to be a product that is uniquely suited to each particular patient. The full amount contracted for such services is, therefore, considered to be due payable when the initial impression is made.
AS A COURTESY TO YOU, Richland Dental Center will, if necessary, accept 50% of this amount at the time of the impression. The balance must be at the time of permanent seating, or no more than 30 DAYS from date of impression, WHICHEVER COMES FIRST, unless prior arrangements have been made with our office manager. We accept insurance for payment; however, you must pay your portion at the time services are rendered.
PROSTHETICS MUST BE SEATED IN A TIMELY MANNER TO INSURE YOU COMFORT, AND PROPER FIT. If you fail to have your prosthetics seated within 60 days from the date of impression, and a second impression must be made, you will be charged an additional amount of one-half of our current charge for such procedure.
WE OFFER YOU QUALITY DENTAL CARE, ECONOMICALLY PRICED, and we want you to feel comfortable with all of our treatments and policies. Please feel most welcome to contact our office manager for any questions you may have.

Patient Signature:_____ Date: _____ Witness: _____

DENTAL AND HEALTH HISTORY

To provide you with the best possible care, please complete the dental & medical history form. All information is completely confidential.

What is the reason for your visit today? _____

_____

Date of Last Dental Visit _____ **Date of Last Cleaning** _____ **Last Full Mouth X-rays** _____

What was done at your last dental visit? _____

_____

Previous Dentist's Name _____

Address _____State _____Zip _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____How often do you floss? _____

What other dental aids do you use? (Sonicare, toothpick, etc.) _____

Do you have any dental problems now? _Yes _No

If yes, please describe: _____

_____

Are any of your teeth sensitive to:
Hot or Cold? _Yes _No
Sweets? _Yes _No
Biting or Chewing? _Yes _No

Do you:
Notice any mouth odors or bad tastes? _Yes _No
Frequently get cold sores, blisters or any other oral lesions? _Yes _No
Do your gums bleed or hurt? _Yes _No
Any gum disease in family members? _Yes _No
Tooth loss? _Yes _No
Have you noticed any loose teeth? _Yes _No
Have you noticed a change in bite? _Yes _No
Does food get caught in your teeth? _Yes _No
If yes, where? _____

Do you:
Clench or grind your teeth _Yes _No
Smoke/chew tobacco _Yes _No
Bite your lips or cheeks regularly _Yes _No
Hold foreign objects with your teeth (i.e. pencils, pipe, pins, nails, fingernails) _Yes _No
Breathe through mouth? (awake or asleep) _Yes _No
Have tired jaws especially in the morning _Yes _No
Smoke/chew tobacco? _Yes _No

Have you ever had:
Orthodontic treatment? _Yes _No
Oral Surgery? _Yes _No
Periodontal Treatment? _Yes _No
Your teeth ground or the bite adjusted? _Yes _No
A bite plate or mouth guard? _Yes _No
A serious injury to the mouth or head? _Yes _No
If so please describe, including cause:
_____

Have you noticed or experienced:
Clicking or popping of the jaw? _Yes _No
Pain? (joint, ear, side of face) _Yes _No
Difficulty in opening or closing mouth? _Yes _No
Difficulty chewing on either side? _Yes _No
Headaches or shoulder aches? _Yes _No
Sore jaw or neck muscles? _Yes _No
Satisfied with your teeth's appearance? _Yes _No
Is keeping all of your teeth very important? _Yes _No
Do you feel nervous about treatment? _Yes _No
if so, what is your biggest concern? _____
Have you ever had an upsetting dental experience? _Yes _No
If yes, describe: _____

Is there anything else about having dental treatment that you would like us to know? _Yes _No
If yes, please describe: _____
_____
_____

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? _Yes _No

If yes, for what? _____

Physician's Name _____ Phone _____

Address _____ City _____State _____Zip _____
2. Have you taken any medication or drugs during the past two years? _Yes _No
3. Are you taking any medication, drugs or pills now? _Yes _No
If yes, please list name and dosage _____
4. Have you ever taken prescription medications for weight loss (diet pills)?__Yes__No
If yes, what type?_____
5. Are you aware of having an allergic (or adverse) reaction to any medication or substance? _Yes _No
If yes, please list: _____
6. Have you been a patient in the hospital during the past five years? _____

7. Indicate which of the following you have had, or have at present. Check "yes" or "no" to each item.

Heart (surgery, disease, attack)	_Yes _No	Ulcers	_Yes _No
Chest Pain	_Yes _No	Diabetes	_Yes _No
Congenital Heart Disease	_Yes _No	Thyroid Problems	_Yes _No
Heart Murmur	_Yes _No	Glaucoma	_Yes _No
High Blood Pressure	_Yes _No	Contact Lenses	_Yes _No
Mitral Valve Prolapse	_Yes _No	Emphysema	_Yes _No
Artificial Heart Valve	_Yes _No	Chronic Cough	_Yes _No
Heart Pacemaker	_Yes _No	Tuberculosis	_Yes _No
Rheumatic Fever	_Yes _No	Asthma	_Yes _No
Arthritis/Rheumatism	_Yes _No	Hay Fever	_Yes _No
Cortisone Medicine	_Yes _No	Latex Sensitivity	_Yes _No
Swollen Ankles	_Yes _No	Allergies or Hives	_Yes _No
Stroke	_Yes _No	Sinus Trouble	_Yes _No
Diet (Special/Restriction)	_Yes _No	Radiation Therapy	_Yes _No
Artificial Joints (hip,knee)	_Yes _No	Chemotherapy	_Yes _No
Kidney Trouble	_Yes _No	Venereal Disease	_Yes _No
Hepatitis A/B	_Yes _No	H.I.V. Positive	_Yes _No
A.I.D.S.	_Yes _No	Sickle Cell Disease	_Yes _No
Cold Sores/Fever Blisters	_Yes _No	Neurological Disorders	_Yes _No
Hemophilia	_Yes _No	Fainting or Dizzy Spells	_Yes _No
Bruise Easily	_Yes _No	Psychiatric/Psychological	_Yes _No
Yellow Jaundice	_Yes _No	Nervous/Anxious	_Yes _No
Epilepsy or Seizures	_Yes _No		

8. Do you use more than two pillows to sleep? _Yes _No
9. Have you lost or gained more than 10 pounds in the past year? _Yes _No

10. Do you have or have you had any disease, condition, or problem not listed? _Yes _No
If yes, please list: _____

11. **Women**: **Pregnant**? _Yes: _No____ Months? **Nursing**? _Yes _No **Taking birth control pills?** _Yes _No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication.

Patient Signature	Dr Signature	Date

Dental Information & Acceptance Form

Patient Name: _____

1. Health Information

I agree to disclose all medical information including any drug allergies, previous illnesses, current medications and supplements, and medical and dental history (such as periodontal disease). Undisclosed medical information can be serious risk factors for you. I agree to allow the use of my information where it is necessary for treatment or to process insurance claims.

2. Drugs, Latex, and Medication

I understand that antibiotics and other medications can cause allergic reactions and/or anaphylaxis, which is a potentially life-threatening condition that can interfere with normal breathing. Also, some antibiotics interfere with birth control pills. Latex allergy can cause rashes and itching. Epinephrine, which is a numbing agent used in some dental projections, increases heartbeat and, depending on my health status, may be dangerous.

3. Needle Stick

If a staff member is inadvertently stuck with a needle or other instrument used on me, I consent to my have blood drawn for analysis at the expense of the dental office.

4. Fillings, Crowns and Unanticipated Root Canals

It is possible that a tooth will need a root canal, even after a simple filling or crown is done.

5. Root Canal Possible Failure

Root Canals can fail and may require additional treatment or require extraction (removal) of the tooth at additional cost to the patient.

6. Porcelain Crowns, Veneers, Bonding, and Cosmetic Fillings

Once a crown, veneer, bonding, or filling is placed, I understand the color cannot be changed without a remake, and that they can chip or break, just like real teeth. I have been counseled, informed, and educated on how it is important to maintain a healthy balanced occlusion (bite). I know that this may be complicated due to stress, clenching, muscles, teeth, and genetics. I am aware that most people grind their teeth subconsciously, which is damaging to the teeth and can break teeth and dental restorations. I have been informed about the need to wear an occlusal splint for protection.

7. Gum Treatment vs. Healthy Mouth Teeth Cleaning

If I do not floss, smoke, or have delayed my dental care, there is a possibility of deteriorating gum/bone condition called periodontal disease which is a bacterial infection of the gum and bone. I am aware that periodontal disease requires more treatment than a routine teeth cleaning.

8. Extractions and Surgery

I understand that all tooth extractions or dental surgeries carry risks. Some are minor, like a dry socket following an extraction. Some could be life threatening, such as post-surgical infection or anaphylaxis.

9. Fee for Additional Care or Specialty Care

I understand that I may need treatment beyond what is originally planned (e.g. a crowned tooth may still need a root canal and may be referred to a specialist for additional care) at additional cost to me.

10. **Limitation of Insurance Coverage**

Often there are charges beyond what insurance will pay such plan limitations (alternate benefit coverage and age guidelines), sterilization fees, nitrous oxide, temporary healing dentures, bleaching, or cosmetic work.

As a courtesy, insurance claims are filed on your behalf and we accept insurance assignment as partial payment for your services. Every effort is made to provide an accurate estimate of your co-payment, but this is **only an estimate** and there is no guarantee of insurance payment. I agree that I am financially responsible for any additional balance after insurance and agree to pay this balance within 30 days of receiving my final statement.

11. 48-Hour Notice of Cancellation

I agree to give 48-business hours notice of cancellation or I will be subject to a $50 broken appointment fee. I understand that leaving a message after the office is closed for the day (or the weekend) before my appointment is NOT sufficient notice.

12. **Requesting Records Transfer**

Professional courtesies occur between dental offices. I understand that any previous records will be sent directly to this dental office only. A fee may be assessed for duplication of records.

13. **Hygiene Appointments**

If I am more than 15 minutes late for my cleaning appointment, I will either accept what appointment time is left or will reschedule and pay the broken appointment fee.

14. **Appointment Times and Emergency Care**

It is our office policy and philosophy to be readily available for any guest in discomfort or in any other emergency situation. This courtesy is extended to you and all patients and we ask for your understanding when these unexpected situations arise. Out of respect for your time, we will keep you informed of such times. We thank you in advance.

_____	_____	_____
Patient Signature	Date	Witness