New Patient Registration Form

Patient Information (CONFIDENTIAL)

Date______________________________
NAME______________________________ Birthdate______________________ Home Phone______________________
Address______________________________ City______________________ State/Zip______________________
Email ______________________________ Cell Phone______________________ Soc. Sec. #______________________

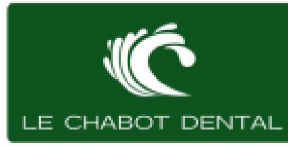
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Spouse or Parent/Guardian's Name______________________________ Work Phone______________________
Spouse or Parent/Guardian's Employer______________________________ City______________________
Whom May We Thank for Referring You?______________________________
Person to Contact in Case of Emergency (living in same home)______________________________ Phone______________________
Person to Contact in Case of Emergency (not living in same home)______________________________ Phone______________________

Responsible Party

Name of Person Responsible for this Account______________________________ Relationship to Patient______________________
Address______________________________ Home Phone______________________
Email (optional)______________________________ Cell Phone______________________
Driver's License #______________________________ Birthdate______________________ SSN______________________
Employer______________________________ Work Phone______________________
Is this person currently a patient in our office? ☐ Yes ☐ No Are there other family members? Yes ☐ No ☐

Insurance Information

Name of Insured______________________________ Relationship to Patient______________________
Birthdate______________________________ SSN______________________ Date Employed______________________
Name of Employer______________________________ Union or Local #______________________ Work Phone______________________
Address of Employer______________________________ City______________________ State/Zip______________________
Insurance Company______________________________ Group #______________________ Policy ID #______________________
Insurance Co. Address______________________________ City______________________ State/Zip______________________
DO YOU HAVE ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, PLEASE COMPLETE THE FOLLOWING:
Name of Insured______________________________ Relationship to Patient______________________
Birthdate______________________________ SSN______________________ Date Employed______________________
Name of Employer______________________________ Union or Local #______________________ Work Phone______________________
Address of Employer______________________________ City______________________ State/Zip______________________
Insurance Company______________________________ Group #______________________ Policy ID #______________________
Insurance Co. Address______________________________ City______________________ State/Zip______________________



Patient Medical History

PATIENT'S NAME ____

Although dental personnel primarily treat the area in and around your 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
Are you taking any medication, pills, or prescription drugs? ____Yes _____No ____N/A
If yes, please list: ____
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 or Trying to get pregnant? ❑ Nursing? ❑ Taking oral contraceptives?
Are you allergic to any of the following? ❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex
❑ Local Anesthetics ❑ Other (Please specify) ____

Do you have, or have you ever 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	❑ Psychiatric Care	❑ Tonsillitis
❑ Blood Transfusion	❑ Excessive Bleeding	❑ Hepatitis B or C	❑ Radiation Treatments	❑ Tuberculosis
❑ Breathing Problems	❑ 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

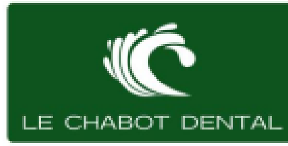
*Condition may require medication. N/A – Not answered by patient

Have you ever had any serious illness not listed above? Yes NO N/A If yes, please specify ____________________

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I also authorize to have photographs of my face, jaws and teeth taken. I understand that these items will be used as a record of my care, and may be used for educational purposes. I further understand that if these items are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

____

Signature of Patient, Parent or Guardian Date



Dental History

NAME: ___________________________

Please check any of the following problems that apply to you.

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, earaches, neck pain
- ☐ Jaw joint pain
- ☐ Teeth or fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifting teeth
- ☐ Bad breath or bad taste in your mouth

Do you have or have you had any of the following:

- ☐ Dentures
- ☐ Partial denture
- ☐ Braces
- ☐ Periodontal (gum) treatments

Please share the following dates:

- ☐ Your last cleaning_____/_____
- ☐ Your last oral cancer screening_____/_____
- ☐ Your last complete X-rays_____/_____

***Name of Previous Dentist*:**

____

City:__________________State:__________

Phone Number: (___)___________________

***General Anesthesia Questions:* (required)**

Height:____________Weight: ____________

Have you ever had any unusual reactions or complications to medications or anesthesia?

☐ Yes ☐ No ***Is yes, please explain below:***

____

____

Are you interested in whiter teeth?

☐ Yes ☐ No ☐ I would like more information.

Do you smoke or use chewing tobacco?

☐ Yes How Much ___________
How Long ___________

☐ No

If you could change your smile, you would:

- ☐ Make it brighter
- ☐ Make it straighter
- ☐ Close spaces
- ☐ Replace black metal fillings with tooth colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

One a scale of 1-10 with 10 the highest rating:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

____

____

What is the most important thing to you about your dental visit?

EMERGENCY CONTACT NOT RESIDING WITH YOU:

Name:__________________________________

Relationship: ____________________________

Phone No. :______________________________

Payment Policy

We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the quality care needed to enjoy a healthy and confident smile.

PAYMENT IN FULL

Full payment is required at the time of service from all patients that do not have insurance coverage.

DENTAL INSURANCE

We are happy to file the forms necessary to see that you receive the full benefits of your coverage. We cannot guarantee any estimated coverage. Your unpaid deductible and any estimated portion of fees not covered by your insurance are due at the time of service. Because the insurance policy is an agreement between you and the insurance company, we ask that patients be directly responsible for all charges. If for any reason your insurance company has not paid their portion within 60 days from the start of treatment, you are responsible for payment at that time.

PAYMENT OPTIONS

- CREDIT CARDS: For your convenience, we have made arrangements to accept payment from all major credit cards.
- PAYMENT PLANS: For patients who desire a monthly payment plan, we offer flexible payment options with no application fees and the loan can be interest-free. Applications are available from our office and approval is provided quickly.
- FLEXIBLE SAVINGS ACCOUNT
- CARE CREDIT OR LENDING TREE

PAST DUE BALANCES

A past due balance is any amount owed from a prior visit where insurance is not pending or an insurance payment has not been received within 60 days. Any delinquent account will be required to pay all past due balances in full before incurring any new charges. All future charges will need to be paid at the time services are rendered. Severely delinquent accounts will be assigned to a collection agency.

RETURNED CHECKS

Checks returned for insufficient funds will be subject to a $30.00 service fee.

BROKEN APPOINTMENTS

A minimum of $50 (per each 30 minutes that have been previously scheduled) will be charged for appointments that are cancelled or broken without a 24-hour advance notice.

INSURANCE CO-PAYS

I understand that my dental insurance may pay less than the actual cost of dental treatment. I agree that it is my responsibility to make my co-payments, and all other payments for each dental procedure.

I have read and agreed to the above payment policy.

Patient Signature:____Date: ____________________________

Patient Name: ____

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act (HIPPA) of 1996, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certification

I understand that Le Chabot Dental has the right to change the Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice.

Le Chabot Dental
1600 150th Ave
San Leandro, CA 94578

I understand that I may request in writing, that Le Chabot Dental can restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that Le Chabot Dental is not required to agree to my request for restrictions.

Patient Name: ____

Relationship to Patient: ____

Signature: ____

Date: ____

Dental Materials Fact Sheet

The following is the Dental Board of California's Dental Material Fact Sheet that we are required to share with all patients in regards to the benefits and risks of materials used to treat patients. The Department of Consumer Affairs (DCA) has no position with respect to the language within the Fact Sheet and its relationship to the DCA website does not constitute an endorsement of the content of this document.

The Dental Board of California
Dental Materials Fact Sheet
Adopted by the Board on October 17th, 2001

As required by Chapter 801, Statues of 1992, the Dental Board of California has prepared this fact sheet to summarize information on the most frequently used restorative dental materials. Information on this fact sheet is intended to encourage discussion between the patient and dentist regarding the selection of dental materials best suited for the patient's dental needs. It is not intended to be a complete guide to dental materials science.

The most frequently used material in restorative dentistry are amalgam, composite resin, glass ionomer cement, resin-ionomer cement, porcelain (ceramic), porcelain (fused-to-metal), gold alloys. Each material has its own advantages and disadvantages, benefits and risks. These and other relevant factors are compared in the attached matrix titled "Comparison of Restorative Dental Materials". A Glossary of Terms is also attached to assist the reader in understanding the term used.

The statements made are supported by relevant, credible dental research published mainly between 1993-2001. In some cases, where contemporary research is sparse, we have indicated our best perception based upon information that predates 1993.

The durability of any restoration is influenced by the dentist technique when placing the restoration, the ancillary materials used in the procedure, and the patient's cooperation during the procedure. Following the restoration of the teeth, the longevity of the restoration will be strongly influenced by the patient's compliance with dental hygiene and home care, their diet and chewing habits.

I ________________________, acknowledge that I have read and understand the information provided
Patient's Name

this Dental Materials Fact Sheet.

Patient Signature:_______________________________Date: ______________________

GENERAL DENTISTRY INFORMED CONSENT

1. Work To Be Done
I understand that I am having the following work done: Fillings_______ Crowns________ Extractions_____ Impacted teeth removed________Root canals________Dentures_______Other_________

2. Drugs & medication (Initials_______)
I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, paint, itching, vomiting, and/of anaphylactic shock.

3. Changes in Treatment Plan (Initials_________)
I understand that during treatment it may be necessary to change or add a procedure because of conditions that were not discovered during the examination but were found while working on the teeth. I give my permission to the Dentist to make any and all changes and additions as necessary as long as I have been informed first.

4. Removal of teeth (Initials__________)
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_____________and any other necessary for reasons in paragraph #3.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 risk involved in having teeth removed, some of which are pain, swelling, and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue. I understand I may need further treatment by a specialist if complications arise during or following treatment, cost of which is my responsibility.

5. Crown, Bridges, and Caps (Initials_________)
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. I realize the final opportunity to make changes in my new crown, bridges, or cap (including the shape, fit, size, and color) will be before cementation. It is also my responsibility to return for permanent cementation within 25 days from tooth preparations. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge, or cap. I understand that there will be additional charges for remakes due to my delaying permanent cementation.

6. Endodontic Treatment (Root Canal) (Initials_______)
I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling material may extend through the tooth which does not necessarily affect the success of the treatment. I understand that endodontic files and reamers are very fine instruments and stressed vented in their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost despite al; efforts to save it.

7. **Periodontal Loss (Tissue & Bone)** (Initials________)
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. Alternative treatment plans have been explained to me, including gum surgery, replacements, and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal conditions.

8.Fillings (Initials_________)
I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay.

I hereby authorize any of the doctors or dental auxiliaries to proceed with and perform the dental restorations and treatment as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees collection cost or court cost that may be incurred to satisfy this obligation.

Signature of Patient________________________ **Name of Patient** ____________________ **Date**____________