DISTINCTIVE DENTAL SERVICE

Date _____ Email _____

Name _____ Home Phone ( ) _____

Address _____ Cell ( ) _____

Married ❑ Single ❑ Student ❑

City _____ Zip _____ How long at present address? _____

Date of Birth _____ Age _____ S.S. # _____ - _____ - _____

Employer _____ Occupation _____

Address _____ Work Phone ( ) _____ Ext. _____

City _____ Zip _____ How long with present employer? _____

Spouse's Name _____ Date of Birth _____

Employer _____ Work Phone ( ) _____ Ext. _____

City _____ Zip _____ S.S. # _____ - _____ - _____

DENTAL INSURANCE INFORMATION

Primary Carrier

Insured's Name _____

Insurance Co. _____

Insurance Phone ( ) _____

Insured's Employer _____

S.S. # _____ - _____ - _____ Group # _____

Secondary Carrier

Insured's Name _____

Insurance Co. _____

Insurance Phone ( ) _____

Insured's Employer _____

S.S. # _____ - _____ - _____ Group # _____

Person **financial responsible** for services _____

If patient is in college, name of school _____

Whom may we thank for recommending Distinctive Dental Service to you? _____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU

Name _____ Address _____

Home Phone ( ) _____ Cell Phone ( ) _____ Work Phone ( ) _____

PATIENT ACKNOWLEDGEMENTS OF PRIVACY ACT & FACT SHEET

I acknowledge that I have reviewed a copy of the Dental Fact Sheet and Notice of Privacy Practice.

X Patient or Guardian Signature _____ Date _____

CONSENT FOR TREATMENT

The undersigned hereby authorizes the Doctor to take 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. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports may be obtained.

X Patient or Guardian Signature _____ Date _____

(Complete back side)

HEALTH HISTORY

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 medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

How long since you have last seen a dentist? _____

Last complete dental exam – Year _____

Last FULL MOUTH X-RAYS – Year _____

Are you having problems now? ❑ Yes ❑ No

If yes, explain: _____

Are you aware of grinding or clenching your teeth? ❑ Yes ❑ No

Do you have headaches, earaches, or neck pains? ❑ Yes ❑ No

Have you worn braces on your teeth? (Orthodontics) ❑ Yes ❑ No

Have you had any periodontal (Gum) treatments? ❑ Yes ❑ No

Do your gums bleed, or feel tender or irritated? ❑ Yes ❑ No

Are your teeth sensitive to hot, cold, sweets, pressure? ❑ Yes ❑ No

Are you under a physician's care now? ❑ Yes ❑ No

If yes, explain: _____

Name of physician _____ Phone _____

Have you been hospitalized or had a major operation in the past 5 years? ❑ Yes ❑ No

If yes, explain: _____

List Medication currently taking _____

_____

Have you ever had a serious neck or head injury? ❑ Yes ❑ No

If yes, explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ❑ Yes ❑ No

Are you on a special diet? ❑ Yes ❑ No

Do you use tobacco? ❑ Yes ❑ No

Do you use controlled substances? ❑ Yes ❑ No

Are you taking any medication for treatment of osteoporosis? ❑ Yes ❑ No

Women: Are you pregnant? ❑ Yes ❑ No

Are you allergic to any of the following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex ❑ Local Anesthetics

❑ Other ❑ If yes, please explain:

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

Yes	No		Yes	No		Yes	No		Yes	No	
❑	❑	AIDS/HIV Positive	❑	❑	Convulsions	❑	❑	Heart Trouble/Disease	❑	❑	Renal Dialysis
❑	❑	Alzheimer's Disease	❑	❑	Cortisone Medicine	❑	❑	Hemophilia	❑	❑	Rheumatic Fever
❑	❑	Anaphylaxis	❑	❑	Diabetes	❑	❑	Hepatitis A	❑	❑	Rheumatism
❑	❑	Anemia	❑	❑	Drug Addiction	❑	❑	Hepatitis B or C	❑	❑	Scarlett Fever
❑	❑	Angina	❑	❑	Easily Winded	❑	❑	Herpes	❑	❑	Shingles
❑	❑	Arthritis/Gout	❑	❑	Emphysema	❑	❑	High Blood Pressure	❑	❑	Sickle Cell Disease
❑	❑	Artificial Heart Valve	❑	❑	Epilepsy or Seizures	❑	❑	Hives or Rash	❑	❑	Sinus Trouble
❑	❑	Artificial Joint	❑	❑	Excessive Bleeding	❑	❑	Hypoglycemia	❑	❑	Spina Bifida
❑	❑	Asthma	❑	❑	Excessive Thirst	❑	❑	Irregular Heartbeat	❑	❑	Stomach/ Intestinal Disease
❑	❑	Blood Disease	❑	❑	Fainting Spells/ Dizziness	❑	❑	Kidney Problems			
❑	❑	Blood Transfusion				❑	❑	Leukemia	❑	❑	Stroke
❑	❑	Breathing Problem	❑	❑	Frequent Cough	❑	❑	Liver Disease	❑	❑	Swelling of Limbs
❑	❑	Bruise Easily	❑	❑	Frequent Diarrhea	❑	❑	Low Blood Pressure	❑	❑	Thyroid Disease
❑	❑	Cancer	❑	❑	Frequent Headaches	❑	❑	Lung Disease	❑	❑	Tonsillitis
❑	❑	Chemotherapy	❑	❑	Genital Herpes	❑	❑	Mitral Valve Prolapse	❑	❑	Tuberculosis
❑	❑	Chest Pains	❑	❑	Glaucoma	❑	❑	Pain in Jaw Joints	❑	❑	Tumors or Growths
❑	❑	Cold Sores/Fever Blisters	❑	❑	Hay Fever	❑	❑	Parathyroid Disease	❑	❑	Ulcers
			❑	❑	Heart Attack/Failure	❑	❑	Psychiatric Care	❑	❑	Venereal Disease
❑	❑	Congenital Heart Disorder	❑	❑	Heart Murmur	❑	❑	Radiation Treatment	❑	❑	Yellow Jaundice
			❑	❑	Heart Pace Maker	❑	❑	Recent Weight Loss			

Have you ever had any serious illnesses not listed above? ❑ Yes ❑ No If yes, please explain: _____

Reviewed by: _____ Date: _____

Comments: _____

MEDICATION NOTIFICATION AND ALERT

If you are taking any of the medications listed below, which belong to a class of drugs called BISPHOSPHONATES, please bring it to our attention.

INTRAVENOUS MEDICATIONS

1. AREDIA (pamidronate)
2. ZOMETA (zolefronate)

ORAL MEDICATIONS

1. ACTONEL (risedronate)
2. DIDRONEL (etidronate)
3. SKELID (tiludronate)
4. FOSAMAX (alendronate)

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.

X Patient or Guardian Signature _____ Date _____

Distinctive Dental Service
Consent for Treatment

1. I hereby authorize and direct the dentist(s) of Distinctive Dental Service and/or dental auxiliaries of his/her choice, to perform the following dental treatment or oral surgery procedures(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.
    a. Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.
    b. Application of plastic "sealants" to the grooves of the teeth.
    c. Treatment of diseased or injured teeth with dental restoratives (fillings and crowns).
    d. Replacement of missing teeth with dental restoratives (fillings and crowns).
    e. Removal (extractions) of one or more teeth.
    f. Treatment of diseased or injured oral tissue (hard and/or soft).
    g. Treatment of malposed (crooked) teeth and/or oral development or growth abnormalities.
2. I understand that there are risks involved in this treatment and hereby acknowledge that these risks will be explained to me, that I will have an opportunity to ask questions regarding the treatment and risks, and the I fully understand the same.
3. I agree to use of local anesthesia, nitrous oxide/oxygen analgesia, sedative drugs, physical restraints or voice control depending on the judgment of the doctor(s). Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves and indentation or ring around the nose which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.
4. I recognize during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being in the professional judgment of the dentist.
5. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting bruising, tingling, and numbness of lip, gums, face, and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks, such as, unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complication.
6. I also authorize the doctor(s) to use photographs, radiographs, other diagnostics materials and treatment records for the purpose of teaching, research, and scientific publications.
7. I will be advised that the success of the dental treatment to be provided will require that the patient and/or parent follow post-operative and post care instructions of the dentist(s). I agree that the success of the treatment requires that all post-operative and post-care to be followed and that regular office visits by my dentist and his/her auxiliaries must be maintained.
8. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner, and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.
9. I further understand that this consent will remain in effect until such a time I choose to terminate it.

Date:_____

Patient's Name: _____

If minor, Parent/Guardian Name:_____

Patient or Patient/Guardian Signature:_____

Witness:_____

Distinctive Dental Service

4330 Barranca Pkwy #220
Irvine, CA 92604
Phone: (949) 857-9220
Fax: (949) 857-4327

HIPAA CONSENT FORM

HIPAA – Notice of Privacy Practice

HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practice is to explain how Distinctive Dental Service may use or disclose your health care information. The Notice also explains the rights that you are guaranteed under HIPAA regulations. Though Distinctive Dental Service has always taken great care to protect the integrity and confidentiality of your health care information, we are now required by the HIPAA Privacy Rule to distribute this notice to you and obtain acknowledgment that you have received the Notice. Signing below indicates that you have received the Notice of Privacy Practice.

I hereby acknowledge that I have received a copy of Distinctive Dental Service Notice of Privacy Practices.

_____
Initials of patient/guardian

Permission to Share Medical Information

My Medical Information may be obtained and exchanged verbally to:

_____
Name/Relationship

_____
Initials of patient/guardian

Permission to Bill Your Insurance

All professional services rendered are charged to the patient. Necessary forms will be completed by Distinctive Dental Service to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage.

I understand my signature authorizes releasing of the information to the insurer or agency given to Distinctive Dental Service for participating health insurance plans.

_____
Signature of Patient/Guardian Date