RANCHO NIGUEL DENTAL GROUP

Gary Mar, D.D.S.

Katie Stern, D.D.S.

Allen A. Ontiveros, D.D.S.

30140 Town Center Drive Laguna Niguel, CA 92677 Tel: 949.249.4180 www.ranchonigueldental.com

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

This form acknowledges your receipt of the HIPAA Notice of Privacy Practices, or our good faith effort to obtain that acknowledgement.

Patient's Name: _____
(Please Print)

Patient/Guardian's Signature: _____ Date: _____

Patient Representative's Signature: _____ Date: _____

FOR OFFICE USE ONLY BELOW THIS LINE

PLEASE SPECIFY THE REASON THE PATIENT CHOSE NOT TO SIGN THE ACKNOWLEDGEMENT OF RECEIPT OF THE HIPAA NOTICE OF PRIVACY PRACTICES:

☐ Patient/Guardian or legal representative received the HIPAA Notice of Privacy Practices but refused to sign the Acknowledgement of Receipt.

☐ Patient/Parent or Legal Representative unavailable to acknowledge receipt of the HIPAA Notice of Privacy Practices.

Staff Signature: _____ Date: _____

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YOUR DENTAL APPOINTMENT
>>APPOINTMENT POLICY<<

Your dental appointment time is reserved specifically for you. We strongly encourage all patients to keep their appointments; however we understand situations may arise that create changes in the patient's schedule.

Please note that if you must change your appointment, Rancho Niguel Dental Group requires at 24-hour notice in order to avoid a cancellation fee of $25.00 or the contracted insurance fee. The cancellation fee covers the cost of materials ordered and prepared for your dental appointment.

Print Name _____

Signature _____

Date _____

ADJUNCTIVE ORAL CANCER SCREENING ACCEPTANCE FORM

Complete each time the examination is performed and place in the patient's file.

Our practice continually strives to provide important enhancements in oral health care for our patients. We are concerned about oral cancer and look for it in all at risk patients.

One person dies every hour from oral cancer in the United States.

Late detection of oral cancer is the primary reason that mortality rates are so dismal. As with most other cancers, age is the primary risk for oral cancer. Though tobacco use is a major predisposing factor, **25% of oral cancer victims have no lifestyle factors.**

Oral Cancer Risk Profile
Increased Risk
-Patients age 40 and older (95% of all cases)
-18-39 years of age combined with any of the following:
-Tobacco use
-chronic alcohol consumption
-Oral HPV infection
Highest Risk
-Patients age 65 and older with lifestyle risk factors
-Patients with history of oral cancer
-**25% of oral cancers occur in people who don't smoke and have no other risk factors.**

We find using the ViziLIte Plus along with a visual oral cancer examination improves our ability to identify suspicious areas that may have been missed during the conventional examination. Early detection of precancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your ife. ViziLite Plus is a painless exam that gives us a better chance to find any oral abnormalities you may have at an early stage.

Dental insurance might not cover the ViziLite Plus exam. However, this office is happy to verify your coverage for you and will also provide you with a medical insurance form for you to use to file this procedure with your medical insurance. The fee for the 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: _____

WELCOME

RANCHO NIGUEL DENTAL GROUP

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1. ABOUT YOU

Today's Date: _____/_____/_____ File #____
Patient Name: _____
Last First MI
What You Prefer To Be Called: _____
Male Female
Birthdate: _____/_____/_____ Age: _____
SS #:_____
Preferred Language: _____
Mailing Address: _____
City: _____ State: ____ Zip: ____
Home Phone #: _____
Work Phone #: _____ Ext: ____
Cell Phone #: _____
Email: _____
Referred By: _____
Employer: _____ How long? ___
Employer's Address: _____
_____
Occupation: _____
Divorced Married Single Widowed Minor
Spouse's Name: _____
Do you have children? How many?_____

2. INSURANCE INFO

Primary Dental Insurance
Co. Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Phone #: _____
Insured's SS#: _____
Group # (Plan, Local, or Policy #): _____
Insured's Name: _____
Relation: _____ Birthdate: ___/_____/_____
Insured's Employer: _____

Secondary Dental Insurance
Co. Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Phone #: _____
Insured's SS#: _____
Group # (Plan, Local, or Policy #): _____
Insured's Name: _____
Relation: _____ Birthdate: ___/_____/_____

3. ACCOUNT INFO

Person ultimately responsible for account
Name: _____
Relation: _____
Billing Address: _____
City: _____
State: _____ Zip: _____
SS #: _____
Driver's License #: _____
Work Phone #: _____
Payment Method:
_____/ _____

_____ (Initials) I here by authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

4. IN EVENT OF EMERGENCY

Whom should we contact? _____
Relation: _____
Home Phone #: _____
Work Phone #: _____
Who is your Medical Doctor? _____
M.D.'s Phone #: _____

5. DENTAL INFO

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation Are you in pain? ☐ Yes ☐ No Length?___

Please indicate ☐ any of the following problems:

☐ Discomfort, clicking, or popping in jaw.
☐ Red, swollen or bleeding gums.
☐ Sensitive tooth, teeth, or gums.
☐ Blisters/Sores in or around the mouth.

☐ Lost/Broken filling(s)
☐ Teeth grinding
☐ Ringing in ears
☐ Broken/chipped tooth

☐ Stained teeth
☐ Locking jaw
☐ Bad breath

Other: _____

Do you require pre-medication ☐ Yes ☐ No ☐ Don't know

Previous Dentist: _____ Phone #: _____

Last Dental Exam: _____/ _____/ _____ Last Dental X-Rays: _____/ _____/ _____

Times a day you brush? _____ Times a week you floss? _____

What type of tooth brush bristles do you use? ☐ Soft ☐ Medium ☐ Hard

How would you rate your smile ? 1 2 3 4 5 6 7 8 9 10

6. MEDICAL HISTORY

Have you taken any medication or drugs the past two years?

Are you taking any medication, drugs, or pills now?

If yes please list name and dosage _____

Have you ever taken/do you take any of the following? (circle all that apply)

Recreational Drugs	Tobacco in any form	Antibiotics
Over-the-counter medicines	Alcohol	Supplements
Weight loss medications	Bisophosphonate (Fosamax)	Aspirin

Are you aware of having an allergic (**or adverse**) reaction to any medication or substance?

If yes, please list: _____

Have you been a patient in the hospital during the past five years?

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

Heart (surgery, disease, attack)	Yes	No	Ulcers	Yes	No	Hepatitis A (Infectious) B (Serum)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact Lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artifical Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

Do you use more than two pillows to sleep?_____

Have you lost or gained more than 10 pounds in the past year?_____

Do you have or have you had any disease, condition, or problem not listed?_____

If yes, please list:_____

Women: Pregnant? Yes, ____ Months **Nursing?** Yes No **Taking birth control pills?** Yes No

I certified that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health, and/or medication. Further, I will not hold my dentist, or any member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature of Patient (Parent or Guardian) Date Signature of Doctor Date

XII. MEDICAL UPDATES

I have reviewed my health history and confirm that it accurately states past and present conditions

Date	Patient Signature:	Changes to health history	Dentist Int
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

RANCHO NIGUEL DENTAL GROUP

Dentist:

Patient:

❶ WORK TO BE DONE

I understand that I am having the following work done. ○Fillings _____ ○Crowns _____ ○Extractions _____ ○Impacted Teeth Removed _____ ○Dentures _____ ○Root Canals _____ ○Periodontal Treatment _____ ○Other_____

❷ DRUGS, MEDICATIONS, AND X-RAYS

I understand that antibiotics, analgesics, and other medications can cause allergic reactions, causing redness, and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. X-Rays are taken by qualified personnel. Exposure to X-Ray radiation (minimal). X-Ray pictures remain the property of this office. Full mouth series of X-Rays may be necessary to aid in diagnosing future dental treatment.

❸ CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions that were not discovered during examination but were found while working on the teeth. For example, root canal therapy may be discovered to be needed during routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

❹ CROWNS, BRIDGES, AND OTHER DENTAL CASTINGS

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 permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including the shape, fit, size, and color) will be before cementation. It is also my responsibility to return for permanent cementation within 20 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge, or cap. I understand there will be addtional charges for remakes due to my delaying permanent cementation.

❺ FILLINGS

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 understand that significant sensitivity is a common after effect of a newly placed filling.

❻ ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occassionally root canal filling material may extend through the tooth which does not necessarily effect the success of the treatment. I understand that endodontic files and reamers are very fine instruments and stresses vented in their manufacture can cause them to separate during use. I understand that ocassionally additional surgical procedures may be necesssary following root canal treatment (apicoectomy). I understand that the tooth may be lost despite all efort to save it.

❼ 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 _____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all 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, tongue and surrounding tissue, or fractured jaw. I understand removal of teeth can result in paraesthesia that can last permanently or for an indefinite period of time and that paraesthesia numbness is a possible risk of injection/extraction. I understand that I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.

❽ PERIODONTAL LOSS (TISSUE AND 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. 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 condition.

❾ DENTURES

I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate dentures (placement of denture immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of more than 30 days, there will be additional charges.

❿ DENTAL MATERIALS FACT SHEET ACKNOWLEDGEMENT

Rancho Niguel Dental Group made the Dental Materials Fact Sheet available to me to read in the office and/or take home. I acknowledge that this was readily available for me and I have chosen to or not to read this material.
I understand that dentistry is not an exact science and that therefore, reputable practicioners cannot properly guarantee results. I acknolwedge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that no other Dentist is responsibly for my dental treatment.

I hereby authorize any of the doctors or dental auxiliaries to proceed with and perform the dental restorations and treatments 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 that I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation.

I understand that this practices provides space, equipment, support personnel and administrative services to allow each dentist to focus on patient care. The individual dentists practicing at this practice are not agents or employees of this practice. Each of them exercises independent professional judgement in the nature and manner of dental care and treatment provided. I ACKNOWLEDGE THAT I AM AWARE THAT ALL DENTISTS ARE NOT EMPLOYEE AGENTS OF THIS DENTAL MANAGEMENT COMPANY.

X_____ Date: _____ X_____Witness: _____
(signature of patient) (signature of doctor)

X_____ Date: _____ X_____ Date: _____
(please print name, if a minor please print minor's name) (Signature Parent/Guardian Spouse)

*If the patient is under the age of 18 years old, please have a parent or legal guardian sign this form

4 CROWNS, BRIDGES, AND OTHER DENTAL CASTINGS

DESCRIBE	PAT INIT	MO.	DAY	YEAR	DESCRIBE	PAT INIT	MO.	DAY	YEAR
DESCRIBE	PAT INIT	MO.	DAY	YEAR	DESCRIBE	PAT INIT	MO.	DAY	YEAR
DESCRIBE	PAT INIT	MO.	DAY	YEAR	DESCRIBE	PAT INIT	MO.	DAY	YEAR
DESCRIBE	PAT INIT	MO.	DAY	YEAR	DESCRIBE	PAT INIT	MO.	DAY	YEAR
DESCRIBE	PAT INIT	MO.	DAY	YEAR	DESCRIBE	PAT INIT	MO.	DAY	YEAR
DESCRIBE	PAT INIT	MO.	DAY	YEAR	DESCRIBE	PAT INIT	MO.	DAY	YEAR
DESCRIBE	PAT INIT	MO.	DAY	YEAR	DESCRIBE	PAT INIT	MO.	DAY	YEAR

5 FILLINGS

TOOTH NUMBER	PAT INIT	MO.	DAY	YEAR	TOOTH NUMBER	PAT INIT	MO.	DAY	YEAR
TOOTH NUMBER	PAT INIT	MO.	DAY	YEAR	TOOTH NUMBER	PAT INIT	MO.	DAY	YEAR
TOOTH NUMBER	PAT INIT	MO.	DAY	YEAR	TOOTH NUMBER	PAT INIT	MO.	DAY	YEAR
TOOTH NUMBER	PAT INIT	MO.	DAY	YEAR	TOOTH NUMBER	PAT INIT	MO.	DAY	YEAR

6 ENDODONTIC TREATMENT (ROOT CANAL)

TOOTH NUMBER	PAT INIT	MO.	DAY	YEAR	TOOTH NUMBER	PAT INIT	MO.	DAY	YEAR
TOOTH NUMBER	PAT INIT	MO.	DAY	YEAR	TOOTH NUMBER	PAT INIT	MO.	DAY	YEAR
TOOTH NUMBER	PAT INIT	MO.	DAY	YEAR	TOOTH NUMBER	PAT INIT	MO.	DAY	YEAR

7 REMOVAL OF TEETH

TOOTH NUMBER	PAT INIT	MO.	DAY	YEAR	TOOTH NUMBER	PAT INIT	MO.	DAY	YEAR
TOOTH NUMBER	PAT INIT	MO.	DAY	YEAR	TOOTH NUMBER	PAT INIT	MO.	DAY	YEAR
TOOTH NUMBER	PAT INIT	MO.	DAY	YEAR	TOOTH NUMBER	PAT INIT	MO.	DAY	YEAR

1 OTHER PROCEDURES

DESCRIBE	PAT INIT	MO.	DAY	YEAR	DESCRIBE	PAT INIT	MO.	DAY	YEAR
DESCRIBE	PAT INIT	MO.	DAY	YEAR	DESCRIBE	PAT INIT	MO.	DAY	YEAR
DESCRIBE	PAT INIT	MO.	DAY	YEAR	DESCRIBE	PAT INIT	MO.	DAY	YEAR