oceanview
dental care

Patient Registration & Health History

905 Calle Amanecer, Suite 265
San Clemente, CA 92673
(949) 388-0780 OceanViewDentist.com
General & Cosmetic Dentistry

Patient Name: _____ Birthdate: _____ ❑ Dr. ❑ Mr. ❑ Mrs. ❑ Ms.

❑ Single ❑ Married Social Security Number: _____-_____-_____ Driver's License Number: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____ Email Address: _____

Employer: _____ City: _____ Work Phone: (_____) _____

Occupation: _____ Name of Spouse: _____

Person Responsible for this Account: _____ Relation to Patient: _____ Dental Insurance? ❑ Yes ❑ No

How did you hear about our office? ❑ Yelp ❑ Google ❑ Mailer ❑ Referral _____ ❑ Other _____

Dental Information

What prompted you to seek dental care at this time? _____

_____

When was your last visit to a dentist? _____

What was done at your last visit? _____

_____

Why are you changing dentists? _____

_____

Has the fear of discomfort kept you from regular dental visits? ❑ Yes ❑ No

Have you lost any teeth? ❑ Yes ❑ No

Have they been replaced by: ❑ Fixed Bridge ❑ Removable Partial ❑ Implant ❑ Denture ❑ Nothing

Are you happy with the replacement? ❑ Yes ❑ No

Are any of your teeth sensitive to: ❑ Heat ❑ Cold ❑ Biting Pressure

Have you had your teeth straightened (braces)? ❑ Yes ❑ No

Did you regularly wear your retainer after your braces? ❑ Yes ❑ No

Are you completely satisfied with your smile? ❑ Yes ❑ No

Is there anything about the appearance of your smile/teeth that you would like to change? _____

If there was a simple, inexpensive way to whiten your teeth, would you be interested? ❑ Yes ❑ No

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Do your gums bleed when you floss? ❑ Yes ❑ No

Have you been told that you have Periodontal/Gum Disease? ❑ Yes ❑ No

Have you had periodontal/gum treatments? ❑ Yes ❑ No

Do you grind or clench your teeth? ❑ Yes ❑ No

Are you aware of your jaw clicking or making grating-like noises? ❑Yes ❑No

Have you ever had TMJ treatments? ❑ Yes ❑ No

Do you suffer from halitosis (bad breath)? ❑ Yes ❑ No

Do you snore or have difficulty falling or staying asleep? ❑ Yes ❑ No

CONSENT: 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 dental needs. I also authorize Doctor to perform all recommended treatment agreed by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk including, but not limited to paresthesia and allergic reactions. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payment is not received by the agreed upon dates, I understand that a monthly 1.5% finance charge (18% APR) or $4 rebilling fee, whichever is greater, may be added to my account. In the case of default of payment, I will additionally pay any collection costs and reasonable attorney fees incurred to effect collection on this account.

Patient (or Guardian) Signature: _____ Date: _____

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Medical History

Patient Name: _____

Family Physician's Name: _____ City: _____ Phone: (_____) _____

Preferred Pharmacy Information: _____ City: _____ Phone: (_____) _____

Have you had or currently have any of the following conditions?

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease or Attack	❑	❑	High Blood Pressure	❑	❑	Hepatitis	❑	❑	Dry Mouth	❑	❑
Angina Pectoris	❑	❑	Stroke	❑	❑	Liver Disease	❑	❑	Radiation Therapy	❑	❑
Heart Murmur	❑	❑	Emphysema	❑	❑	Fainting or Dizzy Spells	❑	❑	Chemotherapy	❑	❑
Mitral Valve Prolapse	❑	❑	Diabetes	❑	❑	Heart Surgery	❑	❑	Psychiatric Care	❑	❑
Rheumatic Fever	❑	❑	Tuberculosis	❑	❑	Hemophilia	❑	❑	AIDS or HIV Positive	❑	❑
Artificial Heart Valve	❑	❑	Artificial Joints (Hip, Knee)	❑	❑	Asthma	❑	❑	Kidney Trouble	❑	❑
Heart Pacemaker	❑	❑	Arthritis	❑	❑	Thyroid Disease	❑	❑	Drug Addiction	❑	❑
Sleep Apnea	❑	❑									

Have you ever had surgery? ❑ Yes ❑ No If yes, list all past surgical procedures. _____

_____

Do you have any disease, problem, or condition not listed? ❑ Yes ❑ No If Yes, what? _____

Are you currently under the care of a Physician? ❑ Yes ❑ No If Yes, why? _____

Are you currently taking any medications, drugs, pills, or multivitamins? ❑ Yes ❑ No If Yes, what? Please list below:

_____ _____

_____ _____

_____ _____

Do you have an allergy to local anesthetic? ❑ Yes ❑ No If Yes, what? _____

Do you have an allergy to any other medication(s)? ❑ Yes ❑ No If Yes, what? _____

Do you have an allergy to latex / rubber products/ metals? ❑ Yes ❑ No If Yes, what? _____

Have you ever had a prescription for Bisphosphonate (Fosmax)? ❑ Yes ❑ No

Are you taking a blood thinner (Coumadin, Warfarin)? ❑ Yes ❑ No

Do you use tobacco products (including vaping devices)? ❑ Yes ❑ No

FOR WOMEN ONLY: Are you pregnant? ❑ Yes ❑ No Are you taking Birth Control Pills? ❑ Yes ❑ No

Nearest Relative not living with you: _____ Relation: _____ Phone: (_____) _____

THE ABOVE INFORMATION IS TRUE: To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medication, I will inform the Doctor at the next appointment. If deemed advisable, I grant permission for my Physician to be contracted for details and advice.

X_____ X_____ _____

Patient Signature | Provider (Dentist/Hygienist) Signature | Date

(For Office Use Only) Medical History Review: I have reviewed this medical history and have added any changes since my last review.

Initial: _____ Date: _____	Initial: _____ Date: _____	Initial: _____ Date: _____
Dr./Hygienist Initial: _____	Dr./Hygienist Initial: _____	Dr./Hygienist Initial: _____

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Airway Screening Questionnaire

905 Calle Amanecer, Suite 265
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General & Cosmetic Dentistry

The latest biomedical research is uncovering the link between sleep-related breathing disorders (SRBD) and our overall health. The American Dental Association (ADA) Council on Dental Practice made a Policy Statement emphasizing the important role dental professionals play in screening and either treating or referring for sleep, breathing and airway related disorders. **In compliance with ADA's position statement, we are providing this screening questionnaire to our patients.**

Please check any of the following signs and symptoms that apply to you:

SLEEP/BREATHING:

- ❑ Snoring or Noisy Breathing
- ❑ Pauses, Gasping or Choking
- ❑ Tossing or Kicking
- ❑ Nightly Awakenings
- ❑ Wake Up Unrefreshed
- ❑ Day-Time Drowsiness
- ❑ Nasal Breathing Issues
- ❑ Mouth Breathing
- ❑ Asthma Symptoms
- ❑ Bed Wetting (current or Past)
- ❑ CPAP Use (current or past)

OCCLUSAL/OROFACIAL:

- ❑ Crowded or Rotated Teeth
- ❑ Gaps Between Teeth
- ❑ Uneven Bite or Bite Issues
- ❑ Retruded or Small Jaw
- ❑ "Gummy Smile"
- ❑ Tongue or Lip Tie
- ❑ Swallow or Speech Issues
- ❑ Chapped Lips, Dry Mouth

TMJ/CRANIOFACIAL:

- ❑ Grinding or Clenching
- ❑ Teeth Wear
- ❑ Gum Recession
- ❑ Teeth Sensitivity
- ❑ Headaches or Migraines
- ❑ Jaw or Facial Pain
- ❑ Jaw Clicking or Noise
- ❑ Ringing in the Ear
- ❑ Locked or Limited Jaw
- ❑ Numbness in Hands, Arms
- ❑ Neck or Shoulder Pain
- ❑ Back or Pelvic Pain
- ❑ Dizziness or Vertigo

NEUROMUSCULAR / SYSTEMIC / PSYCHOSOCIAL:

- ❑ High Blood Pressure
- ❑ Diabetes
- ❑ Arthritis
- ❑ Lupus
- ❑ Ear Infections
- ❑ Acid Reflux (GERD)
- ❑ Fatigue or Tiredness
- ❑ Weight Issues
- ❑ Problems with Memory
- ❑ Problems with Focusing
- ❑ Problems with Learning
- ❑ ADHD or ADD
- ❑ Mood Swings
- ❑ Anxiety or Depression

❑ If none of these symptoms apply to you, please check this box.

Patient Signature: _____ Date:_____

(For Office Use Only) Medical History Review: I have reviewed this medical history and have added any changes since my last review.

Initial: _____ Date: _____ Dr./Hygienist Initial: _____	Initial: _____ Date: _____ Dr./Hygienist Initial: _____	Initial: _____ Date: _____ Dr./Hygienist Initial: _____

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Consent for services, Financial Policy, & Truth-in-Lending Statement

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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 dental needs. I also authorize Doctor to perform all recommended treatment agreed by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk including, but not limited to paresthesia and allergic reactions.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. All emergency dental services and any dental services performed without previous financial arrangements must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services 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 patient's insurance forms and assist in making collections from insurance companies, and will credit any collections from insurance to the patient's account. This dental office cannot render services on the assumption that the resulting charges will be covered by insurance.

I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payment is not received by the agreed upon dates, I understand that a monthly 1.5% finance charge (18% APR) or $4 rebilling fee, whichever is greater, may be added to my account. In the case of default of payment, I will additionally pay any collection costs and reasonable attorney fees incurred to effect collection on this account. In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I understand that the fee estimates for dental care can only be extended for a period of six months from the date of consultation.

Please sign to consent to these terms.

Patient Signature: _____ Date:_____

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HIPPA Acknowledgement

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I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form. I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

Information sharing: Please list any individuals we can share your personal information with other than healthcare providers. If none then please write NONE.

_____

Please sign to consent to these terms.

Patient Signature:_____ Date:_____

Appointment Cancellation Policy Agreement

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Ocean View Dental Care is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen. Please call us at (949) 388-0780 at least 24-hours prior to your scheduled appointment to notify us of any changes or cancellations. If prior notification is not given, you may be subject to a $75 charge for the missed appointment.

Please sign to consent to these terms.

Patient Signature:_____ Date:_____

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Consent for Internet Communications

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I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

Please sign to consent to these terms.

Patient Signature:_____ Date:_____