Patient Health Information **Patient Name:**

These questions are for your benefit to assure full communication of your health status which will be considered when determining your dental treatment and overall dental health. Some questions may seem unrelated to your dental condition, but they are associated with your dental and physical health. Please answer all questions fully.

Medical History:

1. Are you currently under the care of a physician? Yes No

If yes, what are you being treated for?

Physician's name and telephone number:

Date of last physical check up: Results:

2. Have you ever had any serious illness or operation or hospitalization: Yes No

If yes, please describe:

3. Are you currently taking any prescription medications, over the counter medications, supplements, "natural" or homeopathic products? Yes No

If yes, please describe:

4. Have you ever been pre-treated with antibiotics prior to dental treatment? Yes No

5. Are you sensitive or allergic to:

Penicillin Erythromycin Tetracycline Sulfa drugs

Codeine Latex Aspirin Other:

6. Are you sensitive to, or allergic to any metals? Or have you ever had your skin discolored by metals (such as costume jewelry)? Yes No

7. Do you currently have or have you ever had?

	Y	N		Y	N		Y	N
MVP (mitral valve prolapse)			Hepatitis C			Respiratory disease		
Heart murmur			Venereal disease			Sickle Cell disease		
Rheumatic fever			HIV positive			Blood disease		
Joint replacement			AIDS			Mental disorder		
Artificial prosthesis			Blood transfusion			Cerebral palsy		
Glaucoma			Stomach ulcers			Epilepsy or seizure		
Diabetes			Cold Sores			Nervous disorders		
High blood pressure			Bruise easily			Fainting spells		
Heart condition			Sinus trouble			Head injuries		
Stroke			Difficulty swallowing			Leukemia		
Excessive bleeding			Pain in jaw point			Cancer		
Hemophilia			Allergies or hives			Tumors or growths		
Asthma			Psychiatric treatment			Chemotherapy		
Tuberculosis (TB)			Cortisone medicine			Radiation treatment		
Herpes			Thyroid disease			Other:		
Hepatitis A			Kidney disease					
Hepatitis B			Liver disease					

8. Are you taking any recreational drugs (marijuana, cocaine, etc). Yes No
9. Do you have any drug additions (prescription or recreational drugs)? Yes No
10. Have you ever used tobacco products? Yes No
    If yes, type and duration of use:
11. Have you taken Fen-Phen or Redux or Pondimin? Yes No

12. Are you taking any blood thinner medication? Yes No
    If yes, which? Coumadin Plavix Supplement Other:
13. Do you have a cardiac pace maker or have had heart surgery? Yes No
    If yes, please give date of procedure:
14. (Women) Are you pregnant? Yes No
    If yes, how many months?
15. (Women) Have you had any problems with your menstrual periods? Yes No
16. (Women) Do you take birth control pills? Yes No
17. Have you had or are you scheduled to have any cosmetic surgeries? Yes No
18. Please describe any medical condition, problem or disease that you feel I should be aware of:

Dental History:

1. Have you ever had a local anesthetic (such as Novocaine)? Yes No
2. Have you every had any unfavorable reaction from a local anesthetic? Yes No
3. Have you ever had any serious trouble associated with previous dental treatment? Yes No
   If yes, please describe:
4. Do you ever experience sensitivity in your gums or teeth to hot, cold, sugary or acidic foods? Yes No
5. Do you play sports? Yes No
6. Do you often drink sodas (diet or regular) or fruit juices? Yes No
7. How long has it been since your last full mouth x-rays?
8. How long has it been since your last dental treatment?
9. Does dental treatment make you nervous? Yes No

If yes, Slightly Moderately Extremely

10. How would you rate your overall dental health?
11. Please describe any concerns about your oral health:
12. Please describe your concerns about your oral appearance:

Validation and Consent for Treatment: To the best of my knowledge, all of the preceding answers are true and correct. If I ever have a change in my health, or if my medications change, I will, without fail, inform the doctor at my next appointment.

I hereby grant authority to the dentist(s) in charge of the care of the patient, whose name appears in this Health History Form, to administer such anesthetics, analgesics, sedatives, and to perform such operations as may be deemed necessary or available in the diagnosis of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs. I also acknowledge that I have been provided a copy of the Dental Materials Fact Sheet and a copy of the Notice of Privacy Practices taking effect November 30, 2005. All services are rendered and accepted under a fee for service basis and will be paid at the time of treatment. I grant permission to the dentist and assigns to telephone me at my home or work to discuss matters related to this form.

Signed:

Printed name: Date:
Relationship to patient:

PATIENT REGISTRATION

Patient's Last Name: Patient's First Name: M.I.

Date of Birth: Sex: M F Marital Status: Single Married Divorced Widowed

Driver's License Number or ID number:

Parent/Legal Guardian/Legal Trustee (If Patient is a minor)

Home Street Address:

City: State: Zip code:

Mailing Address (If different from home address):

Home Telephone Number: Work Telephone Number:

Cell Number: Email:

Present Employer:

Employer's Address:

EMERGENCY CONTACT

In the event of an emergency, the office requests two persons that we may contact on your behalf:

Emergency Contact Name: Telephone Number:

Emergency Contact Name: Telephone Number:

CONTACT INFORMATION

In delivering dental care to you, it may be necessary to contact you by telephone to arrange appointments, discuss treatment and account balance (if any). Please select the method that you prefer to be contacted. Please allow at least one telephone method since some information regarding treatment may be urgent.

I authorize the office to contact me by the following methods (please initial preferences)

Home Telephone, detailed message on machine or to family member is acceptable.

Home telephone, general message on machine or to a family member is acceptable.

Work telephone, general message is acceptable.

Cell Number Email

PATIENT INFORMATION SHEETS:

We have received a copy of the Dental Materials fact Sheet and the HIPPA Privacy Standards

Signature: **Date:**

PATIENT INSURANCE INFORMATION:

Primary Insurance Company:

Subscriber's Name: | Relationship to Subscriber :

Subscriber's Social Security Number : | Subscriber's Date of Birth :

Group Number : | Contract Number:

Secondary Insurance Company:

Subscriber's Name : | Relationship to Subscriber :

Subscriber's Social Security Number : | Subscriber's Date of Birth :

Group Number: | Contract Number:

ASSISGNMEHT AND RELEASE

I, the undersigned, assign directly to Dr. John Moraga all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid for by insurance. I hereby authorize the doctor to release all information necessary to secure insurance authorization for treatment, required reporting to insurance of all care provided to me, and information required for the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signature: **Date:**

TERMS AND CONDITIONS

As a condition of treatment at this office, I acknowledge that payment is due at the time treatment is started. The dental practice depends upon reimbursement from the patients and patients' insurance carriers for the cost incurred in their care.

I understand that I am personally responsible for payment of all dental services provided whether or not they are covered by my insurance carrier and agree to pay for services at the time treatment is started, or pay all charges within 30 days of billing upon notification that my insurance carrier has failed to pay for services.

I understand that fees listed for a dental case treatment can only be extended for a period of six months from the date of the patients examination.

I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees.

I grant permission to you, or your assigns, to telephone me at home to discuss matters related to this form. I have read the above conditions of treatment and agree to their content.

Signature: **Date:**

COPPERHILL FAMILY DENTAL PRACTICE

I hereby authorize John Moraga, DDS and whomever they designate as their assistants and associates to perform upon me the required services, operation and/or procedures initially discussed and listed in the treatment record. I understand the initial treatment plan was only a tentative treatment plan based on an initial exam and that changes may occur as services are rendered.

I request and authorize them to do whatever they deem advisable if any unforeseen condition arises in the course of these designated operations and/or procedures calling in their judgment for procedures in addition to or different from those initially contemplated.

I consent to the administration of local anesthetic, antibiotics, analgesia, or any other drugs that may be deemed necessary in my case, and I understand that there is always an element of risk inherent in the administration of any drug or anesthesia. This risk includes adverse drug response (allergic reactions), cardiac arrest, thrombophiebitis (irritation and swelling of a vein), pain, discoloration and injury to blood vessels and nerves, which may be caused by injections of any medications or drugs.

I am fully informed, and understand that inherent in any type of surgery and possibilities of certain unavoidable complications. In dentistry, the most common of these complications include post-operative bleeding, swelling or bruising, stiff jaws, loss or loosening of dental restorations. Less common complications can include infection, loss or injury to adjacent teeth and soft tissues, nerve disturbances (e.g. numbness in the mouth, tongue, and lip tissues), jaw fractures, sinus exposure, swallowing or aspiration of teeth or restorations or dental materials, and small root fragments remaining in the jaw which might require extensive surgery for removal.

I realize that in spite of the possible complications and risks, my contemplated surgery treatment is necessary and desired by me. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation/treatment/procedure. However, I will be given full attention to my concerns should there be any that arise along the course of treatment.

I have provided as accurate and complete medical and personal history as possible, including those antibiotics, drugs, medications, foods, metals and/or substances to which I am allergic. I will also without fail, notify the dentist of any changes in my medical or personal information prior to receiving treatment.

I understand that I am the only person responsible for the outcome of delaying or neglecting the recommended treatment or surgery. It is my responsibility as well to ask questions. It is my right to receive answers and responsive explanations about my dental condition and about the contemplated and alternative treatment and procedures and their risk and potential complications.

Signature: Date:
Patient Name: Relationship to Patient:
Witnessed By: Witness Signature:

Copperhill Family Dental Practice

BROKEN APPOINTMENT POLICY

EFFECTIVE 12/01/2009

Dear Patients,

Due to the increasing number of patient who make appointments and fail to show up for them without notifying our office ahead of time, we have no alternative but to begin charging patients for the office time that was reserved for them.

Our new Broken Appointment Policy is as follows:

1. First appointment that is broken without 24 hours in advance notice (except for special emergency situations) will be charged a $50.00 Broken Appointment Fee.
2. Second appointment that is broken without 24 hours advance notice (except for special emergency situations) will be charged a $75.00 Broken Appointment Fee.
3. Third appointment that is broken without a 24 hours advance notice (except for special emergency situations) will be released from the care from our office.

We deeply regret that we must institute this policy but the amount of time and money that is expanded when patients do not show up for their appointment is detrimental to both patient and the dental office.

Patient's Name:

Patient Signature: Date:

Instructions to save form:

- To save changes to the current file, choose File > Save.
- To save a copy to a different file, choose File > Save As.

Please bring completed forms with you to the Office on your first visit. Signatures will be obtained at the time of submission.