

PATIENT NAME _____ DATE _____

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

Dental History

Please Circle

Do you have a specific dental problem? Describe _____ Yes No
Do you have dental examinations on a routine basis? Last visit _____ Yes No
Do you think you have active decay or gum disease? _____ Yes No
Do you brush and floss on a routine basis? Discuss _____ Yes No
Do your gums ever bleed? Discuss _____ Yes No
Do you like your smile? Why? _____ Yes No
Does food catch between your teeth? Any loose teeth? _____ Yes No
Do you want to keep your remaining teeth? _____ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No
Have your past experiences in a dental office always been positive? _____ Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ Yes No
Name of previous dentist (optional): _____
Date of last full mouth x-rays (16 small films or panoramic): _____

Medical History

Are you under a physician's care now? Why? _____ Who? _____ Phone _____ Yes No
Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
Have you ever had a serious injury to your head or neck? Discuss _____ Yes No
Are you taking any medications, pills or drugs? What? _____ Yes No
Are you on a special diet? Discuss _____ Yes No
Are you allergic to any medications or substances? Please check box below _____ Yes No
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other _____
Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives Discuss _____ Yes No

Do you now have or have you ever had any of the following? Please check appropriate boxes.

*If yes to any of the starred conditions, please call prior to your appointment... premedication may be required.

Heart Disease/Surgery* <input type="checkbox"/> Yes <input type="checkbox"/> No	Bruise Easily/Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	Night Sweats <input type="checkbox"/> Yes <input type="checkbox"/> No	Cold Sores <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur* <input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Yellow Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No	Fever Blisters <input type="checkbox"/> Yes <input type="checkbox"/> No
Irregular Heart Beat <input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No
Angina/Chest Pain <input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	X-Ray Treatments (Radiation) <input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Attack/Failure <input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia (Bleeding Problem) <input type="checkbox"/> Yes <input type="checkbox"/> No	Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Aredia I.V. <input type="checkbox"/> Yes <input type="checkbox"/> No	Parathyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No
Mitral Valve Prolapse* <input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Blood Transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No	Zometa I.V. <input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis/Gout <input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No
Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Limbs <input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach/Intestinal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Fever* <input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in Jaw Joints <input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors or Growths <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve* <input type="checkbox"/> Yes <input type="checkbox"/> No	Breathing Problem <input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Weight Loss <input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone Medicine <input type="checkbox"/> Yes <input type="checkbox"/> No	Nervousness <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Pace Maker* <input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No	Artificial Joint* <input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No
Pulmonary Shunt <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Cough <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Alzheimer's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Thirst <input type="checkbox"/> Yes <input type="checkbox"/> No	AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies (Medicines) <input type="checkbox"/> Yes <input type="checkbox"/> No
Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia <input type="checkbox"/> Yes <input type="checkbox"/> No	HIV Positive <input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies (Pollen / Dust) <input type="checkbox"/> Yes <input type="checkbox"/> No
Bacterial Endocarditis <input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Genital Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No	Hives or Rash <input type="checkbox"/> Yes <input type="checkbox"/> No
Unexplained Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Bloody Sputum <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A (Infectious) <input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Addiction/Alcoholism <input type="checkbox"/> Yes <input type="checkbox"/> No	Need Premedication? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Hepatitis B or C <input type="checkbox"/> Yes <input type="checkbox"/> No	Tattoos/Body Piercing <input type="checkbox"/> Yes <input type="checkbox"/> No	Ever taken fen-phen?* <input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever had any other serious illness not checked above? Discuss _____ Yes No

Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____

PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor _____ Date _____ BP _____ Pulse _____

History Review and Significant Findings _____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS	PATIENT'S SIGNATURE	BP	PULSE	REVIEWED BY
_____	_____	None <input type="checkbox"/>	_____	_____	Dr. _____
_____	_____	None <input type="checkbox"/>	_____	_____	Dr. _____
_____	_____	None <input type="checkbox"/>	_____	_____	Dr. _____
_____	_____	None <input type="checkbox"/>	_____	_____	Dr. _____
_____	_____	None <input type="checkbox"/>	_____	_____	Dr. _____
_____	_____	None <input type="checkbox"/>	_____	_____	Dr. _____

PATIENT INFORMATION

DATE _____

NAME _____
LAST FIRST M ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE

SOCIAL SECURITY # _____

ADDRESS _____
STREET APT.# CITY STATE ZIPBIRTHDATE _____ TELEPHONE _____
MONTH DAY YEAR HOME WORK CELL E-MAIL

NAME OF EMPLOYER _____ ADDRESS _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: ☐ PATIENT ☐ GUARDIAN ☐ SPOUSE ☐ FATHER ☐ MOTHER**INSURANCE INFORMATION**MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS - COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY				SECONDARY INSURED			
LAST FIRST M				LAST FIRST M			
STREET CITY STATE ZIP				STREET CITY STATE ZIP			
HOME WORK CELL E-MAIL				HOME WORK CELL E-MAIL			
BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT				BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT			
EMPLOYER DENTAL INS. CO				EMPLOYER DENTAL INS. CO			
SS# SUBSCRIBER # GROUP #				SS# SUBSCRIBER # GROUP #			

**PERSON TO CONTACT
IN CASE OF EMERGENCY**

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

X _____
Patient or Responsible Party

Date _____ State Driver's License # _____

Has any member of your family ever been treated in our office?

☐ Yes ☐ NoWhom may we thank for referring you to our office?
_____**METHOD OF PAYMENT**

Responsible party currently has an account with this office

☐ Yes ☐ No☐ Payment in full at each appointment (cash or personal check)☐ Payment in full at each appointment (☐ VISA ☐ MC ☐ OTHER)

Card # _____ Exp. Date _____

☐ I wish to discuss the Dental Office's Financial Policy**SERVICE CHARGE**

If I do not pay the entire new balance within _____ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of _____% per month (or a minimum charge of \$_____ for a balance under \$_____) which is an annual percentage rate of _____% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Written Financial Policy

Thank you for choosing Marin Center for Aesthetic Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Visa, Mastercard, American Express or cash, check

We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash prior to completion of care for treatment plans of \$1000 or more.

- NO INTEREST¹ Payment Plans² from CareCredit

- o Allow you to pay over time with NO INTEREST¹
- o Convenient, low monthly payment plans² also available
- o No annual fees or pre-payment penalties

Please note:

Marin Center For Aesthetic Dentistry requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

We accept payment in thirds for treatments over \$1500. For larger, more comprehensive treatment plans of \$3000 or more, a 10% deposit is required to secure your initial treatment appointment.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.³

A fee of \$100 is charged for patients who miss or cancel more than 2 times in a calendar year without 24-hour notice.

Marin Center for Aesthetic Dentistry charges \$50 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)

¹If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

²Subject to credit approval

³However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Informed Consent Form for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

As with all surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Some of the more commonly known risks and complications of treatment include, but are not limited to, the following:

- | | |
|---|---|
| 1.) Pain, swelling, and discomfort after treatment; | 8.) Allergic reaction to anesthetic or medication; |
| 2.) Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist; | 9.) A root tip, bone fragment or a piece of a dental instrument may be left in your body, and may have to be removed at a later point in time; |
| 3.) Temporary, or, on rare occasion, permanent numbness, pain, tingling or altered sensation of the lip, face, chin, gums and tongue along with possible loss of taste; | 10.) If upper teeth are treated, there is a chance of a sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment; |
| 4.) Damage to adjacent teeth, restorations or gums; | 11.) Infection in need of medication, follow-up procedures or other treatment; |
| 5.) An altered bite in need of adjustment; | 12.) The need for replacement of restorations, implants or other appliances in the future; |
| 6.) Possible deterioration of your condition which may result in tooth loss; | 13.) Need for follow-up care and treatment, including surgery; |
| 7.) Jaw fracture; | 14.) Prolonged numbness. |

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so he/she can consult with your physician if necessary.

The patient is an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

If you are a woman on birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks and complications or recommended treatment with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

Witness

Patient's Signature

Date

Witness

Signature of parent (if a Minor) or Legal Guardian

Date

GENERAL CONSENT