Personal Information

Patient's Name:_____Date:_____

Address:_____City_____ZipCode_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email:_____ _____ Date of Birth: _____

How did you hear about our office?: _____

Emergency Contact: _____ Phone: _____

Financial Information

Primary Dental Insurance :_____ Phone#: _____

Address: _____

Name of Insured: _____ Date of Birth(of insured): _____

SS# (of insured):_____ Member ID: _____

Group Name/Employer: _____ Group Number: _____

Relationship to Patient: _____ Phone#: _____

Secondary Insurance:_____ Phone#: _____

Address:_____

Name of Insured: _____ Date of Birth(of insured):_____

SS# of insured): _____ Member ID: _____

Group Name/Employer: _____ Group Number: _____

Relationship to Patient: _____ Phone #: _____

Payment Responsibility

For our patients WITHOUT dental benefits… I understand that all responsibility for dental services provided in the office for myself or my dependents is mine, due and payable at the time services are rendered.

For our patients WITH dental benefits… I understand that all services and fees may not be fully covered by an insurance carrier. I understand that I am ultimately responsible for payment of **ALL** dental services provided in this office for myself or my dependents. My co-payment is due and payable at the time services are rendered. Any unpaid insurance balance over 90 days will be transferred to my account and due in 30 days. I authorize the use of my name on dental claims for services provided to me and my dependents. I authorize the payment of claims to this office.

If it becomes necessary to enlist a collection agency, the responsible party agrees to pay all costs of collection.

I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient Signature: _____ Date: _____

Parent or Responsible Party: _____Relationship to Patient:_____

Methods of payment accepted: Cash/Check MC VISA AMEX Care Credit

DENTAL AND MEDICAL HISTORY:

Primary reason for this dental appointment ☐ Exam/Cleaning ☐Emergency ☐Consultation

Dental History

	Please Circle	
Do you have a specific dental problem?	Yes	No
Do you have dental examinations on a routine basis?	Yes	No
Do you have any loose or broken teeth?	Yes	No
Do you brush and floss on a routine basis?	Yes	No
Do your gums ever bleed?	Yes	No
Do you like your smile?	Yes	No
Does food catch between your teeth?	Yes	No
Do you ever have clicking, popping or discomfort in the jaw joint?	Yes	No
Have your past experiences in a dental office always been positive?	Yes	No

Are you interested in discussing any of the following?:

☐Whitening ☐Invisalign ☐Cosmetic Veneers ☐Implants ☐Sedation Dentistry
☐Electric Toothbrush ☐Nightguard for Grinding or Clinching

Medical History

	Please Circle	
Are you under a physician's care now?	Yes	No
Have you ever been hospitalized or had a major operation?	Yes	No
Have you ever had a serious injury to your head or neck?	Yes	No
Are you on a special diet?	Yes	No
Are you ☐ pregnant/ trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives	Yes	No
Are you allergic to any medication, food or substance? Please check box below	Yes	No

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber

Other Allergies:

Are you taking any medications, prescriptions or over the counter? _____

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

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Trouble/Disease	□	□	Ulcers	□	□	Frequent Diarrhea	□	□	Cold Sores	□	□
Heart Murmur	□	□	Leukemia	□	□	Diabetes	□	□	Fever Blisters	□	□
Irregular Heartbeat	□	□	Hemophilia	□	□	Hypoglycemia	□	□	Herpes	□	□
Angina/ Chest Pain	□	□	Swelling of Limbs	□	□	Liver Disease	□	□	Stroke	□	□
Heart Attack/ Failure	□	□	Lung Disease	□	□	Hepatitis A (infectious)	□	□	Convulsions	□	□
Mitral Valve Prolapse	□	□	Breathing Problem	□	□	Hepatitis B (Serum)	□	□	Epilepsy or Seizures	□	□
Scarlet Fever	□	□	Shortness of Breath	□	□	Hepatitis C	□	□	Fainting or Dizziness	□	□
Rheumatic Fever	□	□	Frequent Cough	□	□	Kidney Problems	□	□	Glaucoma	□	□
Artificial Heart Valve	□	□	Sinus Trouble	□	□	Renal Dialysis	□	□	Tumors or Growths	□	□
Pacemaker	□	□	Asthma	□	□	Thyroid Disease	□	□	Phychiatric Care	□	□
Heart Surgery	□	□	Emphysema	□	□	Arthritis/ Gout	□	□	Alzheimer's Disease	□	□
High Blood Pressure	□	□	Tuberculosis	□	□	Rheumatism	□	□	Seasonal Allergies	□	□
Low Blood Pressure	□	□	Cancer	□	□	Pain in Jaw Joints	□	□	Hives or Rash	□	□
Blood Disease	□	□	Radiation Treatments	□	□	Artificial Joint	□	□	Drug Addiction	□	□
Bruise Easily	□	□	Chemotherapy	□	□	Venereal Disease	□	□	Recent Weight Loss	□	□
Anemia	□	□	Stomach Disease	□	□	AIDS/HIV+	□	□		□	□

Have you ever had any other serious illness not checked above? Discuss _____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in health status or if my medicines change, I shall inform the dentist and staff at the next appointment.

_____ Date_____

Patient Signature (Parent or Guardian)

Reviewed by Doctor _____ Date _____ BP _____/_____

Consent for Treatment

1. I hereby authorize and direct the dentist(s) of Ballou Dental Arts and/or dental auxiliaries of his/her choice, to perform the following dental treatment or oral surgery procedure(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 prosthesis (bridges, partial dentures, full dentures).
    E. Removal (extractions) of one or more teeth.
    F. Treatment of diseased or injured oral tissues (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 that I fully understand the same.
3. I agree to the 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 the lips, 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 complications.
6. I also authorize the doctor(s) to use photographs, radiographs, other diagnostic 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 instructions 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 that I choose to terminate it.

Date:_____ Time: _____AM / PM File No. _____

Patient's Name: _____

Name of Parent or Guardian: _____Relationship to Patient: _____

Witness: _____

REQUEST FOR RELEASE OF HEALTH INFORMATION

I, _____, hereby grant permission to _____ to release information related to my health history, status, and treatment, copies of my health record, X-rays and any test results to:

Ballou Dental Arts
29861 Santa Margarita Pkwy, Suite 200
Rancho Santa Margarita, CA 92688

Previous Dentist: _____

Address: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgment of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgment.

You may refuse to sign this acknowledgment

I, _____, have read and received a copy of the Ballou Dental Arts Notice of Privacy Practices.

Signature: _____ Date:_____