Chart #:_____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last First (Preferred Name)

Social Security #:_____ Birth Date: _____

Phone (home): _____ (work):_____(cell):_____

Address: _____
Street Apartment# City State Zip code

E-mail:_____

Date of last dental visit: _____ Reason for this visit: _____

Have you had any of the following? Please check Yes (Y) or No (N).

Y/N	Y/N	Y/N	Y/N
□□AIDS/HIV	□□Excessive bleeding	□□Liver disease	□□Stroke
□□Allergies _____	□□Fainting	□□Mental disorders	□□Tuberculosis
	□□Glaucoma	□□Nervous disorders	□□Tumors
□□Anemia	□□Growths	□□Pacemaker	□□Ulcers
□□Arthritis	□□Hay fever	□□**Pregnancy**	□□Venereal disease
□□Artificial joints	□□Head injuries	Due date: _____	□□Codeine allergy
□□Asthma	□□Heart disease	□□Radiation treatment	□□Penicillin allergy
□□Blood disease	□□Heart murmur	□□Respirator problems	□□Phen-fen/Redux
□□Cancer	□□Hepatitis	□□Rheumatic fever	□□Prophylactic antibiotics
□□Diabetes	□□High blood pressure	□□Rheumatism	
□□Dizziness	□□Jaundice	□□Sinus problems	□□Other: _____
□□Epilepsy	□□Kidney disease	□□Stomach problems	

- Have you ever had any complications following dental treatment? □Yes □No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? □Yes □No
  If yes, please explain: _____
- Are you now under the care of a physician? □Yes □No
  If yes, please explain: _____
- Name of physician? _____Phone: _____
- Do you have any health problems that need further clarification? □Yes □No
  If yes, please explain: _____

To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ _____
Signature of patient, parent or guardian Date

RECALL PATIENTS ONLY:
Have there been any changes in the last 6 months since your last appoint? □Yes □No
If yes, please indicate: _____

Date: _____ Signature:_____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice?

( ) Another patient ( ) Dental office ( ) School ( ) Work ( ) Relatives ( ) Internet ( ) Friends ( ) Other

Name of person or office referring you to our practice: _____

EMPLOYMENT INFORMATION

Employer Name _____ Occupation:_____ Title: _____

Address: _____ _____
Street City State Zip code Phone

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished 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 patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. 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 grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Park Saratoga Dental Treatment Consent Form

1. EXAMINATIONS AND X-RAYS
Initial _____ I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan.

2. DRUGS, MEDICATIONS, AND SEDATION
Initial _____ I have been informed and understand that antibiotics and other medications can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

3. CHANGES IN TREATMENT PLAN
Initial _____ I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to Dr. Ban to make any/all changes and additions as necessary.

4. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)
Initial _____ I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility.

5. FILLINGS
Initial _____ I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I understand that sensitivity is a common after effect of a newly placed filling.

6. REMOVAL OF TEETH
Initial _____ Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize Dr. Ban to remove the following teeth and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the 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 (Parasthesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is may responsibility.

7. CROWNS, BRIDGES, CAPS, VENEERS, AND BONDING
Initial _____ 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 the permanent crowns are delivered. I realize that the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation. It has been explained to me that, in a very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures.

8. DENTURES-COMPLETE OR PARTIAL
Initial _____ I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

9. ENDODONTIC TREATMENT (ROOT CANAL)
Initial _____ I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

10. PERIODONTAL TREATMENT
Initial _____ I understand that I have a serious condition causing gum inflammation and/or bone loss, and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery, and/or extractions. I understand the success of any treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, follow a healthy diet, avoid tobacco products and follow other recommendations.

11. DENTAL MATERIALS FACT SHEET
Initial _____ I have received and read a copy of the dental materials fact sheet as required by law.

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I acknowledge the receipt of and understand post-operative instructions and have been given an appointment date to return.

Signature:_____ **Date:**_____

Doctor:_____ **Witness:**_____

Park Saratoga Dental
12132 Saratoga-Sunnyvale Rd.
Saratoga, CA 95070

HIPPA PATIENT CONSENT FORM

I understand that I have a right to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to early out:

- •Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- •Obtaining payment from third party payers (e.g. my insurance company);
- •The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosure of my protected health information, and my right under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Preference Regarding Communication of Health Information

Who to Contact:
I hereby give permission to Park Saratoga Dental, Kathleen Ban, D.D.S, and Staff, to disclose and discuss any information related to my medical/dental conditions(s) to/with the following family members(s), other relatives(s), and/or close personal friends(s):

Name_____Relationship_____
Name_____Relationship_____

( ) I do NOT wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical/dental condition(s).

How to contact:
I wish to be contacted in the following manner:

Home telephone # _____ ( ) OK to leave message with detailed information
Work telephone # _____ ( ) OK to leave message with detailed information
Cell # _____ ( ) OK to leave message with detailed information

Print Patient's Name_____
Signature_____Date:_____