

Patient Registration

First Name: _____ Last Name: _____ DOB: _____

Sex (Circle): Male Female

Home Address: _____

City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Emergency Contact Name: _____

Home Phone: _____ Cell Phone: _____

Relation to Patient: _____

How Did You Hear About Us? _____

Referred by: Website _____ Insurance _____ Other: _____

Employment: _____

Hobbies: _____

Responsible Party (Insurance Policy Holder):

Full Name: _____

Social Security Number: _____ Date of Birth: _____

Insurance Company: _____ Employer Name: _____

Informed Consent Form for 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 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 surgeries and treatments, there are commonly known risks and potential complications associated with dental treatment such as fillings, crowns, bridges, implants, implant surgeries, extractions, periodontal cleanings, dental surgeries, periodontal surgeries, root canals, orthodontics...etc. 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;
2. Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist;
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;
4. Damage to adjacent teeth, restorations or gums;
5. An altered bite in need of adjustment;
6. Possible deterioration of your condition which may result in tooth loss;
7. Jaw fracture;
8. Allergic reaction to anesthetic or medication;
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;
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;
11. Infection in need of medication, follow-up procedures or other treatment;
12. The need for replacement of restorations, implants or other appliances in the future;
13. Need for follow-up care and treatment, including surgery;
14. Prolonged numbness.
15. Drugs, Latex and Medicines: I understand that antibiotics and other medicines can cause allergic reactions and even life-threatening anaphylaxis. Also, some antibiotics interfere with birth-control pills. Latex allergy can cause rashes and itching. Epinephrine increases heartbeat, and depending on my health, may be dangerous to me.

- 16. Needle Stick:** If someone is inadvertently struck with a needle used on me, I consent to have my blood drawn for analysis.
- 17.** Some teeth may need a root canal even after a simple filling. Fillings and crowns do take away tooth structure and a percentage of these teeth end up needing a root canal after the filling or crown is done.
- 18.** Root Canals can fail and may require additional treatment, or I may end up having the tooth extracted.
- 19.** Porcelain Crowns, Bridges, Veneers, Bonding, and Cosmetic Fillings, are esthetically pleasing. However, I understand that if they chip or break after in use successfully, I am responsible for repairs or remakes. Once a crown, veneer, bonding, or filling is placed, I understand the color cannot be changed. Damage or injury to adjacent teeth, gums and other facial structures can occur when performing these procedures or other adjunctive ones. Pain, swelling, bleeding, infection, bruising, delayed healing, scarring, damage to other teeth and/or roots that may result in the need for tooth repair or loss, loose tooth/teeth, damage to dental appliances, retention of tooth structure, bone or foreign material in the body, cracking and/or stretching of the corners of the mouth, cuts inside the mouth or on the lips, jaw fracture, stress or damage to the jaw joints (TMJ), difficulty in opening the mouth or chewing, allergic and/or adverse reaction to medications and/or materials; Discomfort, increased spacing between teeth, altered bite, altered speech, change in esthetic appearance of teeth and/or smile; The need for future treatment, as this procedure may not prevent future tooth decay, tooth fracture, infection or gum disease; Nerve injury, which may occur from the procedure and/or the delivery of local anesthesia, resulting in altered or loss of sensation, numbness, pain, or altered feeling in the face, cheek(s), lips, chin, teeth, gums, and/or tongue (including loss of taste). Such conditions may resolve over time, but in some cases may be permanent and/or require additional treatment; Occasionally a tooth that has had a crown/bridge may require future Root Canal Therapy.
- 20.** Gum Treatment and Requesting “Just a Cleaning”: If I do not floss or if I smoke, I can expect to have deteriorating gum condition. I agree that if I need gum treatment, I will not insist that I simply get a cleaning (prophylaxis).
- 21.** Extractions and Surgery: I understand that all dental extractions or surgeries carry risks. Some are minor like a dry socket following an extraction. Some are life-threatening such as post-surgical infection or anaphylaxis. I understand that damage to adjacent teeth, gums and facial structures can occur while extracting teeth.

Other Consents:

- 1. Fee for Additional or Specialty Care:** I understand that I may need treatment beyond what was originally planned (a crowned tooth becomes painful and will need a root canal), or I may be referred to a specialist for additional care (root canal was not successful). I agree to be financially responsible for what insurance does not cover.
- 2. Limitations of Insurance Coverage:** There are charges beyond what insurance will pay, e.g. composite fillings instead of amalgam (silver) fillings, temporary dentures, tapping off crowns or bridges, bleaching or cosmetic work. Also, as a service to patients, this office will file insurance claims on their behalf. I understand that what may be quoted as my portion (co-payment) is only an estimate. I agree to be financially responsible for what the insurance does not cover.
- 3. 48-Hour Notice for Cancellation:** I agree to give 48-hour notice for cancellations or pay the broken appointment fee of \$160.00. I understand that leaving a message after the office closed the day (or weekend) before is not sufficient notice.
- 4. Requesting Record Transfers Professional Courtesies** are between dentists. I agree not to request records until I have a new dentist.
- 5. Dental Appointments:** If I am more than 15 minutes late for my dental appointment, I will either take my remaining the only or reschedule and pay a broken appointment fee.

I hereby acknowledge that no guarantees, warranties, or assurance can be given with treatment and that it will be completely successful in function or appearance (to my complete satisfaction). It is anticipated that treatment will work but because of the uniqueness of each individual and every case and because the practice of dentistry is not an exact science, long-term success cannot be promised.

I have read the above and consent to treatment. I hereby acknowledge that I have read this document and have had the opportunity to ask any questions about anything that I do not fully understand.

It is very important that you provide your dentist with accurate medical, dental, and financial information before, during and after treatment. It is equally important that you follow your dentists advise 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 your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

Patient Signature

Date

Printed Patient's Name

MEDICAL HISTORY

PATIENT NAME _____ **DOB** _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? **Yes/No** If yes, please explain: _____

Have you ever been hospitalized or had a major operation? **Yes/No** If yes, please explain: _____

Have you ever had a serious head or neck injury? **Yes/No** If yes, please explain: _____

Are you taking any medications, pills, or drugs? **Yes/No** If yes, please explain: _____

Do you take, or have you taken Phen-Fen or Redux? **Yes/No** If yes, please explain: _____

Are you on a special diet? **Yes/No** If yes, please explain: _____

Do you use tobacco? **Yes/No** If yes, please explain: _____

Do you use controlled substances? **Yes/No** If yes, please explain: _____

Do you need to pre-medicate? **Yes/No** If yes, please explain: _____

Are you allergic to any of the following? (Circle)

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other: If yes, please list: _____

Women only:

Are you Pregnant/Trying to get pregnant? **Yes/No**

Taking oral contraceptives: **Yes/No**

Nursing? **Yes/No**

Do you have, or have you had, any of the following? (Circle)

AIDS/HIV Positive	Excessive Bleeding	Lung Disease
Alzheimer's Disease	Excessive Thirst	Mitral Valve Prolapse
Anaphylaxis	Fainting Spells/Dizziness	Pain in Jaw Joints
Anemia	Frequent Cough	Parathyroid Disease
Angina	Frequent Diarrhea	Psychiatric Care
Arthritis/Gout	Frequent Headaches	Radiation Treatment
Artificial Heart Valve	Genital Herpes	Recent Weight Loss
Artificial Joints	Glaucoma	Renal Dialysis
Asthma	Hay Fever	Rheumatic Fever
Blood Disease	Heart Attack/Failure	Rheumatism
Blood Transfusion	Heart Murmur	Scarlet Fever
Breathing Problems	Heart Pacemaker	Shingles
Bruise Easily	Heart Trouble/Disease	Sickle Cell Disease
Cancer	Hemophilia	Sinus Trouble
Chemotherapy	Hepatitis A	Spina Bifida
Chest Pains	Hepatitis B or C	Stomach/Intestinal
Cold Sores/Fever Blisters	Herpes	Stroke
Congenital Heart Disorder	High Blood Pressure	Swelling of Limbs
Convulsions	Hives or Rash	Thyroid Disease
Cortisone Medicine	Hypoglycemia	Tonsillitis
Diabetes	Irregular Heartbeat	Tuberculosis
Drug Addiction	Kidney Problems	Tumors or Growth
Easily Winded	Leukemia	Ulcers
Emphysema	Liver Disease	Venereal Disease
Epilepsy or Seizures	Low Blood Pressure	Yellow Jaundice

Have you ever had any serious illness not listed above? If yes, please list: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient Signature

Date

DENTAL HISTORY

PATIENT NAME: _____

DATE: _____

1. REASON FOR VISIT: _____
2. DATE OF LAST DENTAL TREATMENT: _____
3. ARE YOU HAVING PAIN AT THIS TIME? YES/NO
4. HAVE YOU EVER HAD:
 - ORTHODONTIC TREATMENT? YES/NO
 - ORAL SURGERY? YES/NO
 - PERIODONTAL TREATMENT? YES/NO
 - YOUR TEETH GROUND OR BITE ADJUSTED? YES/NO
 - A BITE PLATE, DENTURES OR OTHER APPLIANCE? YES/NO
5. HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH? YES/NO
6. DO YOU SUFFER FROM PAIN AND/OR SWELLING OF YOUR GUMS? YES/NO
7. DO YOUR GUMS OFTEN BLEED WHEN YOU BRUSH YOUR TEETH? YES/NO
8. PROBLEMS OF THE JAW. HAVE YOU EVER EXPERIENCED:
 - CLICKING OF THE JAW? YES/NO
 - PAIN (JOINT, EAR, SIDE OF FACE)? YES/NO
 - DIFFICULTY IN OPENING AND CLOSING? YES/NO
 - DIFFICULTY IN SPEAKING? CHEWING? SWALLOWING? YES/NO
 - CHANGES IN THE WAY YOU BITE? YES/NO
9. HABITS—DO YOU:
 - CLENCH OR GRIND YOUR TEETH WHILE AWAKE OR ASLEEP? YES/NO
 - BITE YOUR LIPS OR CHEEKS REGULARLY? YES/NO
 - HOLD FOREIGN OBJECTS WITH YOUR TEETH? (SUCH AS: PENCILS, PIPE, PINS, NAILS, BITE FINGERNAILS?) YES/NO
10. DO YOU FEEL NERVOUS ABOUT HAVING DENTAL TREATMENT? YES/NO
11. BREATHING ISSUES:
 - DO YOU HAVE BREATHING PROBLEMS? YES/NO
 - DO YOU HAVE INTERRUPTED SLEEP PATTERNS? YES/NO
 - DO YOU SNORE DURING SLEEP? YES/NO
12. ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR TEETH? YES/NO
IF NO, PLEASE EXPLAIN WHAT YOU WOULD LIKE TO CHANGE ABOUT THE APPEARANCE:

PATIENT SIGNATURE: _____ **DATE:** _____

FINANCIAL AGREEMENT

Thank you for choosing DaVinci Dentistry as your dental provider. We consider it an honor to have been chosen by you to do so. Our philosophy in serving people is to be informative, honest, and forthright. Nowhere is that more important than in the area of finances. This Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our Financial Agreement, please do not hesitate to ask our business office staff.

DENTAL INSURANCE: As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:

- You must provide us with an insurance card and all the information necessary to verify you and/or your dependents' coverage and file your claim.
- Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you and not your insurance company.
- You are responsible for our fees and not what your insurance company allows or considers "usual, customary and reasonable" all of which vary from one company to another.
- Although we may estimate your insurance benefits, we are not responsible for their accuracy. Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely **YOUR** responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.
- All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all the services we provide are covered benefits. Benefits differ from one company to another. Fees for non-covered services, along with deductibles and copayments are due at the time of treatment.

PAYMENT POLICY

- We accept cash, personal checks, debit cards, AMEX, Visa, MasterCard and Discover.
- After dental insurance has paid its portion, a statement is sent to the mailing address on record, for the remaining balance. Payment is expected within 25 days of the statement date, to avoid finance charges.

Initials: _____

- If the insurance company does not pay in full within 30 days, it will be your responsibility to pay the balance due within two weeks.
- We do not file claims for medical insurance or more than one dental insurance company per patient.

PATIENTS WITHOUT INSURANCE COVERAGE: We provide written estimate of fees, and payment is expected at each visit for services rendered.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for full payment. In the case of divorced/separated parents, the parent accompanying the child is responsible for payment, without any exception. We will not attempt to collect payment from a parent that is not present in the office at that visit.

RETURNED CHECKS: A **\$25.00** charge applies when a check is returned by the bank.

FINANCE CHARGES AND COLLECTION FEES: It is your responsibility to ensure your insurance company pays promptly so you can avoid finances charges. You agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances. We understand temporary financial problems may affect timely payment of your balance. In those situations, we encourage you to communicate any such problems immediately so we may assist you in the management of your account.

OVERDUE BALANCE: An account with an unpaid balance past 90 days will be sent to the collection agency. At that time, you will be responsible for all costs incurred in the collection of your debt: collection agency fees, attorney fees, court fees and any other fees associated with the collection of your debt.

BROKEN OR MISSED APPOINTMENTS: Appointments not kept or changed with less than 48 hours' notice are considered broken. Broken appointments will be rescheduled during the morning hours and subject to additional fees. Broken appointments prevent others from receiving the dental care they deserve.

We take them seriously so please be considerate and inform us in advance if you need to change your appointment.

FEE FOR MISSED APPOINTMENT IF 48-HOUR NOTICE NOT GIVEN: To reschedule or cancel an appointment, you must notify us at least forty-eight (48) hours in advance to avoid a missed appointment fee of **\$160.00**. We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept.

Initials: _____

RECORDS AND REIMBURSEMENTS: Original records including radiographs are the property of this office. If you desire, we will provide you with a copy of your record or radiographs for a nominal duplication fee.

CONSENT & AUTHORIZATION: I authorize dental treatment and agree to pay all related professional fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. I have read and understood this document in its entirety, outlining office policies and financial policies of DaVinci Dentistry. Without any reservations, I agree to abide by the policies outlined herein.

Patient Name: _____ **Date:** _____

Signature: _____

Relationship to patient: _____

If not patient, are you the person legally responsible for this patient? Yes/No (Circle One)

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name: _____

Patient phone/cell number.: _____

I authorize the professional office of my dentist named above to release health information identifying me under the following terms and conditions:

1. Detailed description of the information to be released (i.e. x-rays, clinical notes, treatment plans, appointments, etc.)

2. To whom may the information be released (i.e., spouse, children, legal guardian, etc.):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

3. Expiration date or event relating to the individual or purpose for the release: (i.e., one year, indefinitely, etc.) _____

It is completely your decision whether to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state, or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Signature _____

Date _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____ Print Name _____

Source of Authority (self, parent, or legal guardian) _____

CONSENT TO LEAVE MESSAGE

I give my consent to DaVinci Dentistry doctors and staff to leave a detailed message regarding scheduling, treatment, surgery, medicine information, or other information as necessary (check all that apply)

_____ on an answering machine or voicemail
_____ at home or cell phone

_____ I do not consent to messages being left at home, work or with any other person.
I wish to be contacted directly.

Patient Name (Please Print) _____ **DOB:** _____

Patient Signature _____ **Date:** _____

PHOTOGRAPHY CONSENT FORM/MODEL RELEASE/MEDIA RELEASE

I, (print name) _____, hereby grant permission to DaVinci Dentistry, its employees, representatives, or affiliates to take and use; photographs/digital images, videotape, audio recording or quoted remarks, educational or other PowerPoint or presentation materials of me and/or my children, for use in our social media (such as Facebook or Twitter) or educational materials. These materials might include printed or electronic publications, Web sites or other electronic communications. I further agree that my name and/or children names and identity may be revealed in descriptive text or commentary in connection with the image(s). I authorize the use of these materials indefinitely without compensation to me. All negatives, positives, prints, digital reproductions and video and audio recordings shall be the property of Davinci Dentistry.

Patient Signature

Date