CENTER FOR DENTAL HEALTH, LA JOLLA

REGISTRATION FORM

This information is necessary for our files and will be kept CONFIDENTIAL.

Date_____

PATIENT INFORMATION

Patient Name_____ Sex_____ Birth Date_____

Last First Initial

If Patient is a minor, state name of parent or legal guardian_____ Relationship_____

Residence Address_____

Street City Zip

Email Address_____ Fax Number_____ Mobile Phone_____

Drivers License #_____ Social Security #_____ Residence Phone_____

Employed By_____ How Long_____ Occupation_____

Business Address_____ Business Phone_____

Marital Status_____ Height_____ Weight_____

College Students: Name of School_____ City_____ State_____

Emergency Contact _____ Emergency Contact Phone _____

INSURANCE INFORMATION

Person responsible for this account_____ Relationship_____

Billing Address_____ Phone_____

Street City Zip

PREFERENCE OF PAYMENT: ☐ Cash on day of treatment ☐ Check ☐ Credit Card_____

Name of insurance company (Primary Insurance)_____

Insured Persons Name | Birth Date | Relationship | Social Security #

Name of Group Dental Plan | Group # | Plan # | Name of Union | Local

Name of insurance company (Secondary Insurance)_____

Insured Persons Name | Birth Date | Relationship | Social Security #

Name of Group Dental Plan | Group # | Plan # | Name of Union | Local

TERMS AND CONDITIONS

As a condition of treatment by this office, I understand 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 service performed without prior financial arrangements, must be paid for in cash at the time the services are performed. I understand that dental services furnished to me are charged directly to me and I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

A service charge of 1 and _% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

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

In consideration of the professional services rendered to me, or at my request, by the doctor and/or his staff, 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 billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. 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 attorneys; fees.

IT IS OUR POLICY TO CHARGE $50.00 PER 30 MINUTES FOR MISSED APPOINTMENTS WITHOUT 48 HOUR NOTICE. THIS FEE MUST BE PAID PRIOR TO SCHEDULING ANY FUTURE APPOINTMENTS.

I grant permission to you, or your assigns 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 agree to their content.

Signature of Patient (Parent if Minor)_____ Date_____

PLEASE COMPLETE BOTH SIDES

CENTER FOR DENTAL HEALTH, LA JOLLA

CONSENT FORM

Patient Name_____

INITIAL

_____I understand that I am having any or all of the following treatment done: x-rays, examination, dental cleaning, fillings, inlays/overlays, crowns, bridges, extractions, root canals, dentures, periodontal (gum) treatment, teeth whitening, local anesthesia, other _____

INITIAL

_____I have been informed and understand that antibiotics, analgesics and other medications can cause allergic reactions, including redness and swelling of tissues, itching, vomiting, and/or anaphylactic shock (sever allergic reaction) and they can cause pain, thrombophlebitis (inflammation of vein) from intravenous and intramuscular injections, injury and stiffening of neck and facial muscles. 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 effect of anesthesia, medication and drugs that may have been given to me in the office for my care. I understand that failure to take medication 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,

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 examination, the most common being root canal therapy following routine restorative procedures. I give permission to the treating dentist to make any/all changes as necessary.

INITIAL

_____Alternatives to extractions of teeth have been explained to me (root canal, crowns, and periodontal treatment, etc.) and I authorize the treating dentist to remove teeth as necessary. I understand removal of teeth does not always eliminate all infection and it may be necessary to have further treatment. I understand the risks involved in having extractions, some of which may be pain, swelling, spread of infection, dry socket, excessive bleeding, fractured jaw, loss of feeling in my teeth, lips, tongue and surrounding tissue (paresthetia) that can last for indefinite period of time. 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 my responsibility.

INITIAL

_____For crowns, bridges, veneers, inlays/overlays, and bondings I understand that sometimes it is not possible to match the color of natural teeth exactly with these restorations. I further understand that I may be wearing temporary restorations, which may come off easily and that I must be careful to ensure that they are kept on until the permanent restorations are delivered. I realize that the final opportunity to make changes to my new crown, bridge, inlay/overlay, veneer (including shape, fit, size, and color) will be before cementation. It has been explained to me that in very few cases, cosmetic or other dental procedures may result in the need for future root canal therapy, which can not always be predicted or anticipated. In such instances my treating dentist may decide to perform the root canal or refer me to an endodontist for such treatment, either way I would be responsible for the cost of such a procedure. I understand that cosmetic procedures may affect tooth surfaces and may require modification of oral hygiene.

INITIAL

_____For dentures (complete or partials), I realize these appliances are constructed of plastic, metal, and/or porcelain. Problems associated with these appliances have been explained to me including looseness, soreness, change in my speech, and breakage. I realize the final opportunity to make changes to my dentures (including shape, fit, size, and color) will be the “teeth in wax” try-in visit. I understand that most dentures require relining approximately 3 to 12 months after initial placement. The cost for this procedure is not included in the initial denture fee.

INITIAL

_____For root canal treatments I realize there is no guarantee that this procedure will save my tooth, and that complications can occur from this treatment, and that occasionally, metal objects are cemented in the tooth or extend through the root which does not affect the success of the treatment. I understand that occasionally additional surgical procedures (apicoectomy and/or retrofill) may be necessary following root canal treatment, and that I would be responsible for the cost of these procedures.

INITIAL

_____I have been informed about the risks and consequences of periodontal (gum) disease, if left untreated, including infection, pain looseness and loss of teeth, possible cardiovascular complications and bad breath (Halitosis). Alternative periodontal treatment plans have been presented to me and I understand there is no guarantee that these treatments would save my teeth.

INITIAL

_____I understand that dentistry is not an exact science and that therefore practitioners cannot 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 understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I acknowledge the recipt of and understand post-operative instructions.

Signature of Patient (Parent if Minor)_____Date_____