Ortega Dental Care

We Would Like to Know You Better

Full Name ____

Phone (Home) (____) _____-_______, (Work) (____) _____-_______, (Cell) (____) ______-_______

Address ________________________________ City_____________ State ____ Zip________

Email _______________@_______._____ Date of Birth____/____/_____ SSN ____-____-______

Drivers License # ________________ Marital Status _____ Spouse's Name _________________

Occupation _________________Employer _____________ Work Hours__________________

Last Dental Appointment _________Person Responsible for your Dental Investment _____________

Was the treatment completed? _______________ Did you have a cleaning? _________________

When were Dental x-rays taken? ____

Why did you leave your last Dentist? ____

How Did you hear about us? ____

We want to take Care Of Your Concerns First

What are your present dental problems? ______________________________

Do you avoid brushing any part of your mouth?_________________________

Do your gums bleed when you brushing?______________________________

Are your teeth sensitive to sweets, hot/cold, or biting pressure? _____________

Are you dissatisfied with your teeth and their appearance? ________________

Does dental treatment make you nervous? ____________________________

❑ No ❑ Slightly ❑ Moderately ❑ Very

I think my Dental health is

❑ Excellent ❑ Good ❑ Fair ❑ Poor

If I could change my smile I would make my teeth

❑ Whiter ❑ Straighter ❑ Close Spaces ❑ Repair Chips

Other Concerns/needs of mine are __________________________________

For Insurance Purposes

Name of Policy Holder____________________ Policy holder Social Security #____-____-______

Policy Holder's date of birth___________ Employer__________ Name of Ins. Co.____________

Insurance Company's Phone _______________Group #_________ Ins. Co. Address ____________

____

HEALTH QUESTIONAIRE

Patient's Name______________________________

Sex________ Age________ Height________ Weight________

Date____/____/________ Occupation__________________

Marital Status______________________________

Directions

Please circle the appropriate answer to the questions and fill in the blanks where indicated. Answer all questions completely.

Answers to the following questions are for your records and will be considered confidential.

1. Are you in good health ……………………………………… Yes No
   A. Has there been any change in your general health ………………………………………….. Yes No
2. My last physical examination was on________________________
3. Are you now under the care of physician ………………… Yes No
   A. If so, what is the condition being treated
   ____
4. The name and address of my physician is:
   ____
   ____
5. Have you had a serious illness or operation……………….. Yes No
   A. If so, what was the illness or operation: __________________
   ____
   ____
6. Have you been hospitalized or had serious illness within the last five (5) years……………………………….. Yes No
   A. Do you have a persistent cough or cough up blood………………………………………Yes No
   B. Low blood pressure………………………………….. Yes No
   C. Venereal Disease……………………………………… Yes No
   D. AIDS or HIV+………………………………………… Yes No
   E. Other____
   ____
7. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma………………….... Yes No
   A. Do you bruise easily………………………………… Yes No
   B. Have you ever required a blood transfusion………… Yes No
   If so, explain the circumstances ___________________________
   ____
8. Do you have any blood disorder such as anemia ………..… Yes No
9. Have you had surgery or x-ray treatment for a tumor, growth or other condition of your mouth or lips……………..…..… Yes No
10. Are you taking any drug or medication………………...… Yes No
    If so, what____________________________________
    ____
11. Are you taking any of the following:
    A. Antibiotics or sulfa drugs…………………………...… Yes No
    B. Anticoagulants (blood thinners) ……………………… Yes No
    C. Medicine for high blood pressure………………...…… Yes No
    D. Cortisone (steroids) …………………………...……… Yes No
    E. Tranquilizers………………………………...………… Yes No
    F. Aspirin……………………………………………….… Yes No
    G. Insulin, Tolbutamide (Orinase) or similar drug…..…… Yes No
    H. Digitalis or drugs for heart trouble…………………..… Yes No
    I. Nitroglycerin……………………………..…………… Yes No
    J. Fen-Phen (now, or in the past) or any related drugs such as Ionimin, Adipex, Phentermine, Fastin, Pondimin (Fenfluramin), and Redux (dexfenfluramine) …………………………… Yes No
    K. Oral Contraceptives……………………………...… Yes No
    If so, what are you using ______________________________
    ____
    L. Other ______________________________________
    ____
12. Do you have a heart murmur/mitral valve prolapse……Yes No
13. Do you have any implants and/or Prosthesis (i.e. knee joints, elbow pins, etc.) ………………..…… Yes No
    If so, explain______________________________________
14. Do you drink alcoholic beverages…………………..… Yes No
15. Do you smoke…………………………………..……… Yes No
    If so, how much____________________________________
16. Do you have or have you had any of the following diseases or problems:
    A. Rheumatic fever or rheumatic heart diseases……… Yes No
    B. Congenital heart lesions…………….…………… Yes No
    C. Cardiovascular disease (Heart trouble, heart attack, coronary occlusion, high blood pressure, arteriosclerosis, stroke) ………………………………...……… Yes No
       1) Do you have pain in the chest upon exertion…………………………………….. Yes No
       2) Are you ever short of breath after mild exercise………………...…………… Yes No
       3) Do you get short of breath when you lie down or do you require extra pillows when you sleep……...…………… Yes No
    D. Allergy…………………………………..………… Yes No
    E. Asthma or hay fever…………………..…………… Yes No
    F. Hive or Skin rash………………………………...… Yes No
    G. Fainting spells or seizures………………………… Yes No
    H. Diabetes…………………………………………… Yes No
       1) Do you have to urinate (pass water) more than six (6) times a day………………………… Yes No
       2) Are you thirsty much of the time……...…… Yes No
       3) Does your mouth frequently become dry…..Yes No
    I. Hepatitis, jaundice, or liver disease…………..…… Yes No
    J. Arthritis…………………………………………… Yes No
    K. Inflammatory rheumatism (painful, swollen joints)……………………………..…… Yes No
    L. Stomach ulcers……………………..……………… Yes No
    M. Kidney trouble……………………..……………… Yes No
    N. Tuberculoses…………………………...………… Yes No
17. Are you allergic or have you reacted adversely to:
    A. Local anesthetic………………………………...… Yes No
    B. Penicillin or antibiotics……………...…………… Yes No
    C. Barbiturates, sedatives, or sleeping pills………… Yes No
    D. Sulfa drugs…………………………..…………… Yes No
    E. Aspirin…………………………………...……… Yes No
    F. Iodine……………………………………….…… Yes No
    G. Latex……………………………………….…… Yes No
    H. Other______________________________________
18. Have you had any serious trouble associated with previous dental treatment…………………..……… Yes No
19. Are you pregnant or could you be………………...… Yes No
    If so, when are you due? ______________________________

I certify to the best of my knowledge that the above information is correct and that if there are any changes in the above, I agree to notify my dentist before my next visit.

Patient/Guardian__________________________Date__________

Doctor________________________________Date__________

Updates:

Patient/Guardian__________________ Doctor's Initials______Date______

Patient/Guardian__________________ Doctor's Initials______Date______

Patient/Guardian__________________ Doctor's Initials______Date______

ORTEGA DENTAL CARE

GENERAL DENTISTRY
INFORMED CONSENT

All patients complete 1 thru 4 below, and 5 thru 10 as needed

1. EXAMINATION X.RAYS
I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan *(Initials_______)*

2. DRUGS, MEDICATIONS, AND SEDATION
I have been informed and understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, 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 *(Initials_______)*

3. CHANGES IN TREATMENT PLAN
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 the Dentist to make any/all changes and additions as necessary *(Initials_______)*

4. TEMPOROMANDIBULAR Joint DYSFUNCTION (TMP)
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 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 *(Initials_______)*

5. FILLINGS
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 *(Initials_______)*

6. REMOVAL OF TEETH
Alternatives to removal have been explained to me (root canal therapy crowns, and periodontal surgery etc.) and I authorize the Dentist 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 my responsibility *(Initials_______)*

***7.* CROWNS, BRIDGES, CAPS. VENEERS AND BONDING**
I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I maybe 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 rot 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 *(Initials_______)*

8. DENTURES-COMPLETE OR PARTIAL
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. *(Initials_______)*

***9.* ENDODONTIC TREATMENT (ROOT CANAL)**
I realize there is no guarantee that root canal treatment will save my tooth, and those 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). *(Initials_______)*

10. PERIODONTAL TREATMENT
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. 1 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. *(Initials_______)*

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 understand that each Dentist is an individual practitioner 'and is individually responsible for the dental care rendered to me. I also understand that no other Dentist other than the treating Dentist is responsible for my dental treatment. I acknowledge the receipt of and understand postoperative Instructions and have been given an appointment date to return.

Signature: ______________________________ Date: ______________

Doctor: ______________________________ Witness: ______________

ORTEGA DENTAL CARE

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

USES AND DISCLOSURES OP HEALTH INFORMATION

We use arid disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operation: We may use arid disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: in addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information), or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or Letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you $25.00 to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

ORTEGA **DENTAL CARE**

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services.

A Privacy/Contact Officer has been designated for this office. Please ask our front desk personnel and they will direct you to the Privacy/Contact Officer.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR NECESSARY USE OF PERSONAL HEALTH INFORMATION

____

Print Patient's Name Date

I, ____, have received

(*Signature of Patient*)

a copy of this office's NOTICE OF PRIVACY PRACTICES as required by federal law.

I, ____, consent to the

(*Signature of Patient*)

use and disclosure of my personal health information by your office during Treatment, Billing/Payment and Dental Office Operations as outlined in the Notice of Privacy Practices.