PATIENT INFORMATION FORM Today's Date: ___________________

Patient Name: First ___________________________ MI _____ Last __________________________ Nickname_____________

Address: Street ________________________________ City ____________________ State ________ Zip_________________

Phone: Home ____________________________ Work ___________________________ Cell ___________________________

E-Mail Address: ____ Cell Phone Carrier: ____________________

What is your preferred method of contact? ___ Home phone ___ Work phone ___ Cell Phone ___ Text ___ E-mail

Date of Birth: _____/_____ /_______ Social Security Number: _________________________________

Sex: ___Male ___ Female ___ Other Marital Status: ___ Married ___ Single ___ Divorced ___ Separated ___ Widowed

Patient Employed By: _______________________________________ Occupation: ________________________________

Address: Street ________________________________ City ____________________ State ________ Zip_________________

In case of emergency, who should we notify? ____________________________________

Relationship: ______________ Home Phone: __________________________ Cell Phone: __________________________

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Is the patient a minor? ___ Yes ___ No Full Time Student? ___ Yes ___ No School: ___________________________

Mother's Name: ____________________________________ Father's Name: ____________________________________

Name of responsible party: First ___________________________________ Last _________________________________

Primary Residency: ____ Both parents ____ Mom ____ Dad ____Shared Custody ____ Guardian

<u>Dental Benefit Plan Information</u>

Primary Dental Plan Name: ________________________________ Subscriber ID # ________________________________

Subscriber Name: ____ Employer: ____________________________________

Patient relationship to subscriber: Self Spouse Child Dependent

Secondary Dental Plan Name: : _______________________________ Subscriber ID # ______________________________

Subscriber Name: ____ Employer: ____________________________________

Patient relationship to subscriber: Self Spouse Child Dependent

<u>Medical Benefit Plan Information</u>

Plan Name: ____ Subscriber ID # _______________________________

Whom may we thank for referring you? ____

If not referred by someone, how did you hear about us? ____
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Your Smile Analysis

Are any of your teeth causing pain today? Y N

Are you happy with the appearance of your teeth? Rate them on a scale of 1 (unhappy) – 5 (happy) **1 2 3 4 5**

Would you like your teeth to look better or different? Y N

Do you wish your teeth were whiter? Y N

Do you wish your teeth were straighter? Y N

Do you show your teeth when you smile? Y N

Do your teeth cause you to avoid any food or drinks that you like? Y N

Do you have any sensitivity to hot, cold, or sweets? Y N (If yes, circle which one causes sensitivity)

Are you aware of clenching or grinding your teeth? Y N

Do you have problems with teeth tipping, shifting or breaking? Y N

Do you have problems with teeth or fillings breaking? Y N

Have you ever had periodontal (gum) treatments? Y N

Do your gums bleed or feel tender or irritated?

How often do you brush your teeth? _____ How often do you floss? _____ Waterpik?_____

How long since you have seen a dentist? _____

What do you like about your teeth / smile? _____

What do you dislike? _____

Policies:

Payment: Payment is due at the time services are rendered. We accept cash, check, credit card and Care Credit When treatment is diagnosed and/or recommended, you will re presented with a treatment plan showing you the estimated costs and financial policies of this practice to approve before any treatment is rendered.

Scheduling Appointments: we reserve the doctor and hygienist's time on the schedule for each patient procedure and we are diligent about being on time. Because of this courtesy, when a patient calls to cancel an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require a 48-hour notice to reschedule an appointment. With less than 48-hour notice, a fee of **$50**, or deposit to reserve another appointment time again, may be required. To serve all our patients in a timely manner, we may need to reschedule an appointment if a patient is 15 or more minutes late in arriving to our practice. A no-show to any scheduled appointment may result in a fee of **$50**, or deposit to reserve another appointment time again, may be required

Authorizations: I understand that the information I have given today is correct to the best of my knowledge. I authorize the dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment. _____ (Initial)

I have read the above and agree to the terms. _____ (Initial)

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me. _____ (Initial)

Signature: _____ Date: _____

CONFIDENTIAL HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?
   If NO, explain: _____
2. Yes / No Has there been a change in your health within the last year?
   If YES, explain: _____
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain: _____
4. Yes / No Are you being treated by a physician now? If YES, explain: _____
   Date of last medical exam? _____ Reason for exam: _____
5. Yes / No Have you had problems with prior dental treatment?
   If YES, explain: _____
   Date of last dental exam: _____ Name of last treating dentist: _____
6. Yes / No Are you in pain now?
   If YES, explain: _____

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Chest pain (angina)	Yes / No	Blood in stools	Yes / No	Frequent vomiting
Yes / No	Fainting spells	Yes / No	Diarrhea or constipation	Yes / No	Jaundice
Yes / No	Recent significant weight loss	Yes / No	Frequent urination	Yes / No	Dry mouth
Yes / No	Fever	Yes / No	Difficulty urinating	Yes / No	Excessive thirst
Yes / No	Night sweats	Yes / No	Ringing in ears	Yes / No	Difficulty swallowing
Yes / No	Persistent cough	Yes / No	Headaches	Yes / No	Swollen ankles
Yes / No	Coughing up blood	Yes / No	Dizziness	Yes / No	Joint pain or stiffness
Yes / No	Bleeding problems	Yes / No	Blurred vision	Yes / No	Shortness of breath
Yes / No	Blood in urine	Yes / No	Bruise easily	Yes / No	Sinus problems

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Heart disease	Yes / No	AIDS/HIV	Yes / No	Psychiatric care
Yes / No	Family history of heart disease	Yes / No	Surgeries	Yes / No	Osteoporosis
Yes / No	Heart attack	Yes / No	Hospitalization	Yes / No	Thyroid disease
Yes / No	Artificial joint	Yes / No	Diabetes	Yes / No	Asthma
Yes / No	Stomach problems or ulcers	Yes / No	Family history of diabetes	Yes / No	Hepatitis
Yes / No	Heart defects	Yes / No	Tumors or cancer	Yes / No	Sexual transmitted disease
Yes / No	Heart murmurs	Yes / No	Chemotherapy	Yes / No	Herpes
Yes / No	Rheumatic fever	Yes / No	Radiation	Yes / No	Canker or cold sores
Yes / No	Skin disease	Yes / No	Arthritis, rheumatism	Yes / No	Anemia
Yes / No	Hardening of arteries	Yes / No	Emphysema or other lung disease	Yes / No	Liver disease
Yes / No	High blood pressure	Yes / No	Kidney or bladder disease	Yes / No	Eye disease
Yes / No	Seizures	Yes / No	Stroke	Yes / No	Transplants
Yes / No	Cosmetic surgery	Yes / No	Eating disorders	Yes / No	Tuberculosis

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Aspirin	Yes / No	Valium	Yes / No	Tetracycline
Yes / No	Darvon	Yes / No	Demerol	Yes / No	Vicodin
Yes / No	Codeine	Yes / No	Penicillin	Yes / No	Percodan
Yes / No	Latex	Yes / No	Food	Yes / No	Nitrous oxide
Yes / No	Local anesthetic (Novocain or Xylocaine)	Yes / No	Erythromycin	Yes / No	Metal

Others: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?
(Please circle Yes or No for each)

Yes / No	Recreational drugs	Yes / No	Tobacco in any form	Yes / No	Antibiotics
Yes / No	Over-the-counter medicines	Yes / No	Alcohol	Yes / No	Supplements
Yes / No	Weight loss medications	Yes / No	Bisphosphonate (Fosamax)	Yes / No	Aspirin

Please list all prescription medications: _____

VI. WOMEN ONLY (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, what month? _____
Yes / No Are you nursing?
Yes / No Are you taking birth control pills?

VII. ALL PATIENTS (Please circle Yes or No for each)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____
_____
Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: _____
Yes / No Have you ever taken Fen-Phen? If YES, when: _____

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____	_____	_____	_____
Signature of Patient (Parent or Guardian)	**Date**	**Signature of Dentist**	**Date**

MEDICAL UPDATES
I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS

(AS 6/2009)

INFORMED CONSENT

1. WORK TO BE DONE

I understand that the following treatments may be performed on me as part of my dental treatments: Fillings, Bridges, Crowns, Extractions, Impacted Teeth Removal, Root canals, Dentures, Partial Dentures, Periodontal Treatments and possible other dental treatments.

2. FILLINGS

Fillings are procedures in which the dentist removes decayed tooth structure of a faulty restoration and replaces it with composite or silver Amalgam fillings. I understand that these procedures can cause the teeth to be sensitive to hot and cold as well as chewing. The majority of the time, these sensitivities are temporary and they will go away within one (1) or two (2) weeks. However, there are times that due to the depth of the filling in the tooth, the pulp or the nerve of the tooth becomes irreversibly sensitive. In these cases, the tooth will need to be treated for root canal therapy and might possibly require a post and crown to be fully restored. I understand that the dentist can not guarantee that the teeth receiving fillings will not need to receive the above mentioned additional procedures and that I will be responsible for payments for any additional treatments needed to restore the teeth, if the initial filling procedure does not correct the problem.

3. DRUG AND MEDICATIONS

I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, vomiting and/or anaphylactic shock (sever allergic reaction).

4. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change procedures because of conditions found while working on the teeth were not discovered during examination. I give my permission to the Dentist to make those changes as necessary.

5. 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 teeth outlined in the treatment plan and any others necessary. 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 risk 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 surround tissue (Parasthesia) that can last for an indefinite period of time (day or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment.

6. ANESTHESIA

I realize the risks involved in receiving a local anesthetic, some of which are: partial facial paralysis, inflamed tissue, adverse reactions to drugs causing cardiac arrest, miscarriage, hemorrhage, nerve damage and/or numbness.

7. CROWNS, BRIDGES AND CAPS

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, and that if I don't have the permanent crown(s) placed permanent serious damage or loss of the tooth/teeth involved may ensue, and that if I delay placement I may cause the teeth involved to move so that the permanent crown no longer will fit properly.

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 these appliances have been explained to me including looseness, soreness, and possible breakage, and relining due to tissue and bone change. I understand the wearing of dentures is difficult. Sore spots, altered speech and difficulty in eating are common problems. Immediate dentures (placement of denture immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointed may result in poorly fitted dentures. If a remake is required due to my delays of more than 30 days there will be additional charges.

9. ENDODONTIC TREATMENT (ROOT CANAL)

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 though the root which does not necessarily effect the success of the treatment, and that this treatment often requires multiple visits and that I can cause serious damage or loss of the tooth/teeth involved if I so not complete the prescribed treatment.

10. PERIODONTAL LOSS (TISSUE AND BONE)

I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. The alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

11. a. ARBITRATION

Arbitration is the final process for the resolution of any dispute or controversy between a patient, or a personal representative of the patient, as the case may be, and Christopher Phen D.D.S. concerning the quality of patient services provided to the patient under this agreement for any dispute or controversy concerning the construction, interpretation, performance or breach of this agreement. By

entering into this agreement, the patient agrees that such disputes shall be submitted to binding arbitration under the appropriate rules of the American Arbitration Association (AAA).

I. Patient understands and agrees that any and all disputes between patient and Christopher Phen D.D.S. or its providers shall be resolved by submission to binding arbitration conducted by the American Arbitration Association (AAA). Such disputes or controversies include, but are not limited to, complaints concerning the quality, necessity or outcome of services provided pursuant to this Informed Consent Form, as well as the construction, interpretation, performance or breach of the terms of this Informed Consent Form. Patient further recognizes that by consenting to binding arbitration, patient is giving up the right to have such disputes decided in a court of law and/or before a jury.

II. A declaration of a court or other tribunal of competent jurisdiction that any portion of this agreement to arbitrate is void or unenforceable shall not render any other provision hereof void or unenforceable.

b. INITIATION OF ARBITRATION

Arbitration can be initiated by filing a demand for arbitration with the AAA, location at 225 Bush Street, 18th floor, San Francisco, CA. 94104-4207, Telephone number (415)981-3901. A demand form may be obtained from the AAA.

c. COSTS

In all arbitration matters submitted to the AAA, the party initiating demand for the arbitration shall advance all administration fees connected therewith. If the patient prevails in arbitration, the patient may be entitled to reimbursement of costs including reasonable attorney's fees incurred in connection with the arbitration proceedings. Any such award of cost shall be made at the discretion of the arbitrator.

d. LOCATION

Arbitration proceeding shall occur in the county where the patient's treatment was performed, unless all parties to the arbitration otherwise mutually agree in writing.

e. FORMS OF DECISION

The parties agree that the arbitrators shall issue a written opinion. The award of the arbitrators shall be binding and may be enforced in any court having jurisdiction thereof by filling a petition of enforcement of said award. The arbitrator's award shall be accompanied by a written decision explaining the facts and reasons upon which the award is based, including the findings of fact and conclusions of law made and reached by the arbitrator.

I hereby request and authorize the dentist, and their staff, to perform dental work upon me for the purpose of attempting to improve my appearance, function and the health of my mouth, teeth, bone and tissue, as explained above.

The effect and nature of the proceeding to be performed, and the risks involved, as well as the possible alternative methods of treatment have been fully explained to me.

I also authorize the operating Dentist and Assistants to perform any other procedure which they may deem necessary or desirable in attempting to improve the condition stated on the diagnostic treatment from, or treat unhealthy or unforeseen conditions that may be encountered during the operation.

I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation.

I know that the practice of Dentistry and surgery 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 treatment which I have herein requested and authorized.

Alternatives and possible bad reactions have been explained to me in detail. Complications, such as infection, hemorrhage and/or bleeding, scarring, contraction, possible deformities, prolonged healing time over the estimate, reaction to any drugs before, during and after surgery, numbness or itching of the tongue, lip, teeth, tissues (Parasthesia), fractured jaw, Temporo mandibular joint (TMJ) Complications, which could cause localized and systemic pain requiring future treatments including joint surgery, etc., have been clearly explained to me.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT AND THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE. ANYTHING I DID NOT UNDERSTAND HAS BEEN EXPLAINED TO ME.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL BINDING ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 11 OF THIS CONTRACT.

Signature: _____ Witness: _____ Doctor: _____
(Patient or Legal Representative)

Date: _____ Date: _____ Date: _____

Lincoln Crossing Dental

109 Ferrari Ranch Rd, Lincoln, CA 95648 (916) 253-7000

Acknowledgement of Receipt of Notice of Privacy Practices & Dental Material Fact Sheet

(You may refuse to sign this acknowledgement)

I, _____, acknowledge that I have received a copy of the Dental Material Fact Sheet (5/04) and a copy of the Notice of Privacy Practices from Lincoln Crossing Dental.

Cell Phone Authorization

I consent to Lincoln Crossing Dental using my cell phone number for the following:

(Choose as many as apply)

- Calls regarding treatment, insurance, appointments, and my account _____
- Text messages regarding appointments _____

I understand I can withdraw this consent at any time.

My cell phone # is: (____) _____ Service Carrier: _____

_____ _____

Print Name Date

_____ _____

Patient Signature Parent Signature if a minor

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

[ ] Individual refused to sign

[ ] Communication barriers prohibited obtaining the acknowledgement

[ ] An emergency situation prevented us from obtaining acknowledgement

[ ] Other (Please specify) _____