Chart #:

FOR OFFICE USE ONLY

**WELCOME TO OUR PRACTICE**

**Orange County Oral Surgery and Periodontics**

**29829 Santa Margarita Parkway Suite #300**

**Rancho Santa Margarita, Ca 92688**

Patient Name:  Date*:*

Last, First MI (Preferred Name)

Gender: M/F Family Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security *#:*  Birth Date: \_\_\_\_\_\_\_\_\_\_\_

Phone (Home):  (Work):  Ext: Best time to call: \_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Relationship)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:  \_\_\_\_\_\_\_\_\_

Street Apartment #

*CA*

Date of Last Dental Visit: Reason for this visit:

***Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please circle your responses.***

Please describe your current health: Excellent Good Fair Poor

Please describe the symptoms you are currently having today: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have there been any changes in your general health in the past year? ­­ Yes No

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you now under a doctor’s care for a particular problem at this time? Yes No

If yes, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last physical exam \_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized or had a serious illness? Yes No

If yes, why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had surgery? Yes No

If yes, when and what for? Date of surgery:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason for surgery:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of surgery:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason for surgery:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH HISTORY UPDATE**

Date Comments Doctor’s Signature

**\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **PATIENT MEDICAL HISTORY**  **Do you have or have you ever had:** |  |  |  |  |  |
| Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)? | Yes | No | Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)? | Yes | No |
| Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)? | Yes | No | Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily? | Yes | No |
| Kidney disease or kidney failure, requiring dialysis? | Yes | No | Liver disease (jaundice, hepatitis A, B, or C)? | Yes | No |
| Thyroid disease? | Yes | No | Arthritis? | Yes | No |
| Stomach ulcers or colitis? | Yes | No | Significant weight loss or gain? | Yes | No |
| Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth? | Yes | No | Seizures, convulsions, epilepsy, fainting or dizziness? | Yes | No |
| Frequent or recurring mouth sores? | Yes | No | Sinus or nasal problems? | Yes | No |
| Glaucoma? | Yes | No | Sleep apnea? | Yes | No |
| Diabetes? | Yes | No | Osteoporosis or osteopenia? | Yes | No |
| Any cancer, radiation, or chemotherapy? Yes No  Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of your last treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Yes No  If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **FAMILY MEDICAL HISTORY**  **Do you have a family history of any of the following? If yes, indicate the relationship.** | | | | | | | | |
| Diabetes? Yes | No | Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Cancer? | Yes | No | Relationship \_\_\_\_\_\_\_\_\_\_\_ |
| Heart disease? Yes | No | Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Bleeding problems? | Yes | No | Relationship \_\_\_\_\_\_\_\_\_\_\_ |
| Tumors? Yes | No | Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Lung disease? | Yes | No | Relationship \_\_\_\_\_\_\_\_\_\_\_ |
| **SOCIAL HISTORY** | | | | | | | | |
| Have you ever smoked, vaped or chewed tobacco? Yes No  Which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If yes, for how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |  | | --- | | **Do you use:** | | Alcohol? Yes No How often? \_\_\_\_\_\_\_\_\_\_\_\_\_  Marijuana? Yes No How often? \_\_\_\_\_\_\_\_\_\_Recreational drugs? Yes No How often?\_\_\_\_\_ | | | | | | | | | |  |
| **Have you ever sought professional care or been hospitalized for:** | | | | | | | | |  |
| Substance abuse? Yes | | | No | **Explain:** | | | | | Yes No How often? \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Emotional disorders? Yes | | | No | **Explain:** | | | | |  |
| Alcoholism? Yes | | | No | **Explain**: | | | | |
| **DENTAL HISTORY** Have you had any adverse effects from dental treatment? Yes No If Yes, please explain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |  |

**ALLERGIES: Are you allergic to or have you had an adverse reaction to: (Circle Yes/No)**

|  |  |  |  |
| --- | --- | --- | --- |
| Latex? Yes | No | Codeine or other pain killers? Yes | No |
| Food products? Yes | No | Aspirin, Motrin, Aleve, or ibuprofen? Yes | No |
| Sedatives, barbiturates? Yes | No | Penicillin or other antibiotics? Yes | No |

**Medications: Are you using any of the following: (Circle Yes/No)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Antibiotics? | Yes | No | Prescription pain medication? | Yes | No |
| Anticoagulants (blood thinners)? | Yes | No | Aspirin or drugs such as Motrin, Aleve, Ibuprofen? | Yes | No |
| Heart medications? | Yes | No | Insulin or oral anti-diabetic drugs? | Yes | No |
| Steroids (cortisone, prednisone, etc.)? | Yes | No | Blood pressure medications? | Yes | No |
| Antianxiety agents, antidepressants or other psychiatric medications? | Yes | No | Bisphosphonates, medications to strengthen your bones, IV medications, or any other cancer drugs? If yes, list drugs used and time of use.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes | No |
| Please list any specific medications indicated above and/or any other medications not listed above that you are currently taking including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals:   |  |  |  |  | | --- | --- | --- | --- | | **Medication** | **Dosage** | **Medication** | **Dosage** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | | | | | | |

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes No If yes, which anesthetic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship? \_\_\_\_\_\_\_\_\_\_\_\_

Other drug or food allergies not listed above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible.

To the best of my knowledge, the above information is complete and correct.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient, parent, guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of patient, parent, guardian/Relationship Doctor’s Signature

# Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative

 Dental Office  Yellow Pages  Newspaper  School  Work  Other

Name of person or office referring you to our practice: DDS Richard Ting

## 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, parent or guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_Relationship to Patient: \_\_\_\_\_\_\_\_\_

Signature of guarantor of payment/responsible party

**Spouse or Responsible Party Information**

The following is for:  the patient's spouse  the person responsible for payment

Name:

 Male  Female  Married  Single  Child  Other

Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date:

Phone (Home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Work): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext: \_\_\_\_\_\_ Best time to call:

Address:

Street Apartment #

City State Zip Code

**Employment Information**

The following is for:  the patient  the person responsible for payment

Employer Name: Occupation:

Address:

Street City, State Zip Code Phone

**Insurance Information**

**Primary** Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is insured a patient?  Yes  No

Last First MI

Insured's Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #:

Insured's Address:

Street City State Zip Code

Insured's Employer Name:

Address:

Street City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Plan Name and Address:

**Secondary** Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is insured a patient?  Yes  No

Last First MI

Insured's Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #:

Insured's Address:

Street City State Zip Code

Insured's Employer Name:

Address:

Street City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Plan Name and Address:

Orange County Oral Surgery and Periodontics

29829 Santa Margarita Parkway Suite #300

Rancho Santa Margarita, Ca 92688

PATIENT E‐MAIL AND TEXT MESSAGING REGISTRATION FORM

Due to the changing world of healthcare and technology, Orange County Oral Surgery and Periodontics now has the ability to provide our patients with certain types of information via e-mail and/or text messaging. If you wish to have the opportunity to receive information of this type, please complete the form below. Orange County Oral Surgery and Periodontics believes strongly in protecting the privacy of our patients. When you provide this information to us, it is only used as a way to communicate with you. In order to protect your privacy, no confidential or personal information will be sent from Orange County Oral Surgery and Periodontics via email or text messaging. Orange County Oral Surgery and Periodontics does not share the names, e‐mail addresses, and/or telephone numbers of patients with any other company, or with any other patient. Please print all information neatly and legibly.

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E‐mail address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

O Yes, I would like to receive e‐mail and text messaging confirmations.

O I do not wish to be contacted via email. (Text messaging only)

O I do not wish to be contacted via text messaging. (Email only)

O I do not wish to be contacted by either text messaging or email.

I hereby give Orange County Oral Surgery and Periodontics permission to send messages to me via email and/or text messaging as means of communication as indicated by my selection above.

Patient/ Legal Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_