Main Dental Care

655 South Main St. #230 • Orange, CA 92868 • Tel: 714.543.2815 • Fax: 714.543.6121
email: office@maindentalcare.com • www.maindentalcare.com

Name____ Male ☐ Female ☐

Address______________________________City________________State__________Zip__________

Home Phone____________________Work Phone____________________Cell Phone____________________

Email Address____Date of Birth____________________

Occupation______________________________Employer______________________________

Whom may we thank for referring you? ____

Person to contact in case of emergency____________________________Phone Number____________________

Person responsible for dental investment ☐ Self ☐ Parent ☐ Spouse ☐ Other____________________

Responsible Party's Name________________________________Contact Phone Number____________________

For Insurance Purposes:

Name of Policy Holder____Date of Birth____________________

Relationship to Patient____SSN____________________

Member I.D.______________________________Employer______________________________

Insurance Company____

Insurance Company Number____________________________Group Number____________________

HIPAA Compliance Statement

Your health information may be used in our office to conduct scheduling and coordination of care between the doctor, dental assistant, hygienist and business office staff. We may include your health information with an invoice to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. Your health information may be reviewed during the routine process of certification, licensing, credentialing activities or auditing for quality assurance.

Communication with our patients is an important part of our philosophy. We prefer to communicate with you directly but we may incorporate the use of phone messages, postcards and letters. We will make every effort to respect your privacy and honor your request for confidentiality. If you have special needs with regard to privacy issues, please put them in writing for the office so that we may address your concerns.

Financial Information

I have read and truthfully answered the above questions to the best of my knowledge. I authorize the doctor and/or staff to release all information necessary to secure payment of my benefits from my insurance company.

I understand that fees may vary at the time of service due to the extent of treatment. Fees are estimates only and are not a guarantee of payment by my insurance company. I understand that payment of this account is my responsibility, regardless of the amount my insurance company reimburses before or after payment is made.

Patient Signature:____Date:______________
Doctor Signature:____Date:______________

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MEDICAL HISTORY

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Patient Name ____Nickname____________________________Age___________

Name of Physician and their Specialty____

Most recent physical examination______________________________Purpose____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD: YES NO

1. hospitalization for illness or injury______________________ ☐ ☐
2. an allergic reaction to____________________________ ☐ ☐
   - ☐ aspirin, ibuprofen, acetaminophen, codeine
   - ☐ penicillin
   - ☐ erythromycin
   - ☐ tetracycline
   - ☐ sulfa
   - ☐ local anesthetic
   - ☐ fluoride
   - ☐ metals (nickel, gold, silver, _____________)
   - ☐ latex
   - ☐ other_______________________________________
3. heart problems, or cardiac stent within the last 6 months___ ☐ ☐
4. history of infective endocarditis____________________ ☐ ☐
5. artificial heart valve, repaired hear defect (PFO)___________ ☐ ☐
6. pacemaker or implantable defibrillator________________ ☐ ☐
7. orthopedic implant (joint replacement)________________ ☐ ☐
8. rheumatic or scarlet fever___________________________ ☐ ☐
9. high or low blood pressure___________________________ ☐ ☐
10. a stroke (taking blood thinners)______________________ ☐ ☐
11. anemia or other blood disorder______________________ ☐ ☐
12. prolonged bleeding due to a slight cut (INR>3.5)__________ ☐ ☐
13. emphysema, shortness of breath, sarcoidosis_____________ ☐ ☐
14. tuberculosis, measles, chicken pox____________________ ☐ ☐
15. asthma____ ☐ ☐
16. breathing or sleep problems (ie sleep apnea, snoring, sinus)_ ☐ ☐
17. kidney disease_____________________________________ ☐ ☐
18. liver disease______________________________________ ☐ ☐
19. jaundice____ ☐ ☐
20. thyroid, parathyroid disease, or calcium deficiency_________ ☐ ☐
21. hormone deficiency_________________________________ ☐ ☐
22. high cholesterol or taking statin drugs__________________ ☐ ☐
23. diabetes (HbA1c = ________)_________________________ ☐ ☐
24. stomach or duodenal ulcer___________________________ ☐ ☐
25. digestive disorders (ie celiac disease, gastric reflux)________ ☐ ☐
26. osteoporosis/osteopenia (ie taking bisphosphonates)______ ☐ ☐

YES NO

27. arthritis____ ☐ ☐
28. autoimmune disease____________________________________ ☐ ☐
    (ie rheumatoid arthritis, lupus, scleroderma)
29. glaucoma____ ☐ ☐
30. contact lenses_______________________________________ ☐ ☐
31. head or neck injuries__________________________________ ☐ ☐
32. epilepsy, convulsions (seizures)__________________________ ☐ ☐
33. neurologic disorders (ADD/ADHS, prion disease)___________ ☐ ☐
34. viral infections and cold sores___________________________ ☐ ☐
35. any lumps or swelling in the mouth_______________________ ☐ ☐
36. hives, skin rash, hay fever_____________________________ ☐ ☐
37. STI / STD / HPV______________________________________ ☐ ☐
38. hepatitis (type_______) ________________________________ ☐ ☐
39. HIV / AIDS____ ☐ ☐
40. tumor, abnormal growth________________________________ ☐ ☐
41. radiation therapy_____________________________________ ☐ ☐
42. chemotherapy, immunosuppressive medication____________ ☐ ☐
43. emotional difficulties__________________________________ ☐ ☐
44. psychiatric treatment__________________________________ ☐ ☐
45. antidepressant medication______________________________ ☐ ☐
46. alcohol / recreational drug use__________________________ ☐ ☐

ARE YOU:

47. presently being treated for any other illness______________ ☐ ☐
48. aware of a change in your health in the last 24 hours_______ ☐ ☐
    (ie fever, chills, new cough, or diarrhea)
49. taking medication for weight management_______________ ☐ ☐
50. taking dietary supplements______________________________ ☐ ☐
51. often exhausted or fatigued______________________________ ☐ ☐
52. experiencing frequent headaches__________________________ ☐ ☐
53. a smoker, smoked previously or use smokeless tobacco_____ ☐ ☐
54. considered a touchy / sensitive person____________________ ☐ ☐
55. often unhappy or depressed______________________________ ☐ ☐
56. taking birth control pills_________________________________ ☐ ☐
57. currently pregnant_____________________________________ ☐ ☐
58. prostate disorders______________________________________ ☐ ☐

Describe any current medical treatment, impending surgery, genetic/developmental delay, or other treatment that may possibly affect your dental treatment (ie Botox, Collagen injections)

____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

Patient Signature:____Date:________________

Doctor Signature:____Date:________________

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DENTAL HISTORY

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Patient Name ________________________________ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist________________________________ How long have you been a patient? ____________________ Months/Years
Date of most recent dental exam ________ / ______ / ______ Date of most recent x-rays __ / ______ / ______
Date of most recent treatment (other than a cleaning) ____ / ______ / ______
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely
WHAT IS YOUR IMMEDIATE CONCERN?____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [_______]____________ ☐ ☐
2. Have you had an unfavorable dental experience?____________ ☐ ☐
3. Have you ever had complications form past dental treatment?____________ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?____________ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?____________ ☐ ☐
6. Have you had any teeth removed or missing teeth that never developed?____________ ☐ ☐

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing?____________ ☐ ☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?____________ ☐ ☐
9. Have you ever noticed an unpleasant taste or odor in your mouth?____________ ☐ ☐
10. Is there anyone with a history of periodontal disease in your family?____________ ☐ ☐
11. Have you ever experienced gum recession?____________ ☐ ☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?____________ ☐ ☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?____________ ☐ ☐

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years?____________ ☐ ☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?____________ ☐ ☐
16. Do you feel or notice any holes (ie pitting, craters) on the biting surface of your teeth?____________ ☐ ☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?____________ ☐ ☐
18. Do you have grooves or notches on your teeth near the gum line?____________ ☐ ☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?____________ ☐ ☐
20. Do you frequently get food caught between any teeth?____________ ☐ ☐

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)____________ ☐ ☐
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together?____________ ☐ ☐
23. Do you avoid or gave difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?____________ ☐ ☐
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn?____________ ☐ ☐
25. Are your teeth becoming more crooked, crowded, or overlapped?____________ ☐ ☐
26. Are your teeth developing spaces or becoming more loose?____________ ☐ ☐
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together?____________ ☐ ☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?____________ ☐ ☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?____________ ☐ ☐
30. Do you clench your teeth in the daytime or make them sore?____________ ☐ ☐
31. Do you have any problems with sleep (ie restlessness), wake up with a headache or an awareness of your teeth?____________ ☐ ☐
32. Do you wear or have you ever worn a bite appliance?____________ ☐ ☐

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change?____________ ☐ ☐
34. Have you ever whitened (bleached) your teeth?____________ ☐ ☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth?____________ ☐ ☐
36. Have you been disappointed with the appearance of previous dental work?____________ ☐ ☐

Patient Signature:________________________________ Date:______________
Doctor Signature:________________________________ Date:______________

Main Dental Care Consent & Office Policy

I, _________________________, consent to be a patient at the above named office and agree to a radiographic and clinical examination. **I also understand and consent to the following:**

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. I understand that at any time during my dental treatment, unforeseen changes in my treatment plan may be necessary. The dentist will keep you informed during the process of any changes that could occur during treatment including but not limited to removal of decay and/or crowns and/or fillings.

5. If you have insurance it is a contract between you and the insurance company. We will make every effort to assist you with your insurance and will prepare and submit insurance claims for you. We will estimate what the insurance company will pay and you will be responsible for any estimated co pays at the time of service. If your insurance pays less than what was estimated, you will be responsible to pay any remaining portion.

6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

____ ___________________

Signature of Patient or Patient's Representative **Date**

____

Print Name

____

____

Relationship to Patient (if not signed by the patient)

Financial Policy

Thank you for choosing us as your dental health care provider. We believe that all patients deserve the very best dental care we can provide. We also believe that everyone benefits when specific financial arrangements are agreed upon. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment. All patients must complete our information and insurance forms before seeing the doctor.

Full payment is due at time of service. We accept cash, checks, Visa, Mastercard, Discover, American Express credit cards, and debit cards.

Regarding Insurance

We request that any co-payments, deductibles, and any services not covered by your insurance plan be paid at the time the service is provided. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance unless you bring in all insurance information at your initial visit. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to your account. Please be aware some and possibly all of the services provided may be non-covered services and not considered reasonable, usual, and customary under the terms of your dental and/or medical policy.

Adult Patients

Adult patients are responsible for full payment at the time of service. If you are unable to pay at this time, be sure to point this out when you arrive for you appointment.

Minor Patients

The adult accompanying a minor and/or the parents (or guardians) are responsible for full payment at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to a credit card or payment by cash or check at time of service has been verified.

Billing

All accounts which have not paid the estimated portion of their bill at the time of service will incur a $3.00 billing charge each month until the balance is paid. Balances which are 60 days old or older will incur a monthly 1.5% finance charge with equals an 18% per annum rate. There is also a $30 returned check fee.

Refunds

Refunds for overpayment will be sent after all treatment is completed and insurance has been collected.

Collections

Any account that has not received payment in 60 days will be handed over to a collection agency that will pursue the responsible party for reimbursement. This will negatively impact your credit history and limit the treatment you can receive at our office.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. We look forward to providing the highest quality dental care in a relaxing and caring atmosphere.

I have thoroughly read the Financial Policy. I understand and agree to this Financial Policy.

____   ____________________
Signature of Patient or Patient's Representative   **Date**

____
Print Name

____
Relationship to Patient (if not signed by the patient)

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have been provided a copy of Main Dental Care's Notice of Privacy Practices, which describes how my health information may be used and disclosed.

I understand that Main Dental Care has the right to change the Notice of Privacy Practices at any time. I will be provided a copy of the updated version and may also contact the Office Manager at any time to request a current Notice of Privacy Practices.

By signing below, I acknowledge that I have read the Notice of Privacy Practices:

____ ________________

Signature of Patient or Patient's Representative **Date**

____

Print Name

____

Relationship to Patient (if not signed by the patient)

____

Name(s) of Family Member(s) or Representative(s) that Main Dental Care can release information to:

Late Cancellation or No Show Guidelines

We make every effort to give patients appointments which fit their schedules as well as our own. We call, text, and email patients whenever possible to confirm their appointments. Most businesses that deal with reserved appointments charge a fee equal to lost revenue for an appointment not canceled within 48 hours in advance. However, our office cancellation fees are minimal and only intended as a courtesy for our dedicated professionals' time. Our office fee for a missed appointment is only$100. We hope that patients keep their appointments as this fee do not offset office losses when a patient does not keep an appointment.

Our office is closed on Fridays and we ask that if you need to cancel a Monday appointment, please do so by the previous Thursday. We understand that no one likes to pay for a doctor's time when no service has been provided. By informing us of your cancellation within 48 hours notice, you'll be giving a chance to those individuals who are truly in need of seeking dental care.

By signing below, I am acknowledging that I have read and understand this office policy.

Patient signature: ____

Date: _____/______/______

655 South Main St, #230
Orange, CA 92868
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X-Ray/Photography Waiver

Patient Name ___________________________, ______________________ _________________
Last First MI

I hereby authorize and consent to the use of certain photographs/x-rays taken by Main Dental Care. I hereby grant permission to reproduce, publish, print, use and distribute copies of such photographs/x-rays in an official medical / dental publication or in the form of prints, electronic media, slides, or films for all use including those in connection with diagnostic consultations, articles, or lectures dealing with dental care, cosmetic dentistry, or for any diagnostic, educational or marketing purpose.

I specifically waive any claims for invasion of my personal privacy, which might accrue to me on account of the use of such pictures without my express consent to each instance.

Please initial ONE of the following:

_____ I DO consent to the use of my photos/x-rays for as described above.

_____ I DO NOT consent to the use of my photos/x-rays for use as described above.

_____ I DO consent to the use of my photos/e-rays as described above EXCEPT full face or identifying views.

Please sign and date:

Patient Signature _______________________________________ Date ___________________