Chart # _____
FOR OFFICE USE ONLY.

Patient Information

Patient Name: _____ Date: _____

Gender _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Email Address _____

Preferred appointment times: □ Morning □ Afternoon □ Evening □ Any Time DM DT OW DT OF OS

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____

Have you ever had any of the following? Please check those that apply:

□ AIDS
□ Allerqies _____
_____
□ Anemia
□ Arthritis
□ Artificial Joints
□ Asthma
□ Blood Disease
□ Cancer
□ Diabetes
□ Dizziness
□ Epilepsy
□ Excessive Bleeding
□ Fainting
□ Glaucoma
□ Growths
□ Hay Fever
□ Head Injuries
□ Heart Disease
□ Heart Murmur
□ Hepatitis
□ High Blood Pressure
□ Jaundice
□ Kidney Disease
□ Liver Disease
□ Mental Disorders
□ Nervous Disorders
□ Pacemaker
□ Pregnancy
Due date:
□ Radiation Treatment
□ Respiratory Problems
□ Rheumatic Fever
□ Rheumatism
□ Sinus Problems
□ Stomach Problems
□ Stroke
□ Tuberculosis
□ Tumors
□ Ulcers
□ Venereal Disease
□ Codeine Allergy
□ Penicillin Allergy
OTHER:
□ _____
□ _____

- Have you ever had any complications following dental treatment? □ Yes □ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? □ Yes □ No
  If yes, please explain:
- Are you now under the care of a physician? □ Yes □ No
  If yes, please explain:
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? □ Yes □ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

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

□ Dental Office □ Yellow Pages □ Newspaper □ School □ Work □ Other

Name of person or office referring you to our practice: _____

Spouse or Responsible Party information

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

Narne: _____

□ 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 EmDlover 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: _____

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 1%% 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

Chart #: _____
FOR OFFICE USE ONLY

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

E-Mail Address: _____ Family Status: _____

Consent for Internet Communications

I grant my permission to Tanada Lee Family Dental Care to upload and store confidential patient information — including account information, appointment information and clinical information — to the secured web site for Tanada Lee Family Dental Care I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand Tanada Lee Family Dental Care and myself are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that Tanada Lee Family Dental Care is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand Tanada Lee Family Dental Care is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the Tanada Lee Family Dental Care web site with my ID and password. I also agree to immediately notify Tanada Lee Family Dental Care of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns. I also understand State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand Tanada Lee Family Dental Care will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my patient information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that Tanada Lee Family Dental Care has the right to monitor, retrieve, store, upload and use my patient information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand Tanada Lee Family Dental Care will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand Tanada Lee Family Dental Care CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above regarding the secured uploading of patient information to the web site for Tanada Lee Family Dental Care and grant Tanada Lee Family Dental Care permission to securely upload my patient information to the web site.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

PATIENT CONSENT TO TREATMENT

In reading and signing this form it is understand that English is the language that I understand and use to communicate.

1. DRUGS, MEDICATIONS, AND ANESTHESIA:

I understand that antibiotics, analgesics, and other medications may cause adverse reactions, some of which are, but not limited to, redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest r

I understand that medications, drugs, and anesthetics may cause drowsiness and lack of coordination, which can be increased by the use of alcohol or other drugs. I have been advised not to consume alcohol, nor operate any vehicle or hazardous device while taking medications and/or drugs, or until fully recovered from their effects (this includes a period of at least twenty four (24) hours after my release from surgery).

I understand that occasionally, upon injection of a local anesthetic, I may have prolonged, persistent anesthesia, numbness, and/or irritation to the area of injection.

1 understand that if I select to utilize Nitrous Oxide, 'Atarax*, Chloryl hydrate, Zanax, or any other sedative, possible risks include, but are not limited to, loss of consciousness, obstruction of airway, anaphylactic shock, cardiac arrest I understand that someone needs to drive me home from the dental office after I received sedation. 1 also understand that someone needs to watch me closely for a period of 8 to 10 hours, following my dental appointment, to observe for possible deleterious side effects, such as obstruction of airway

(initials)_____

2 HYGIENE AND'PERIODONTICS (TISSUE AND BONE LOSS):

I understand that the long term success of treatment and status of my oral condition depends on my efforts at proper oral hygiene (i.e. brushing and flossing) and maintaining regular recall visits.

. PERIODONTICS-1 understand that I have a serious condition, causing gum and bone inflammation and/ or loss, and that it can lead to loss of my teeth and other complications. The various treatment plans have been explained to me, including gum surgery, replacements and/ or extractions. I also understand that although these treatments have degree of success, they cannot be guaranteed. Occasionally, treated teeth may require extraction.

(initials)_____

3.CROWN AND BRIDGE (CAPS):

I understand that sometimes it is possible to match the color of natural teeth exactly with artificial teeth. I understand that at times, during the preparation of a tooth for a crown, pulp exposure may occur, necessitating possible root canal therapy.

I understand that like natural teeth, crowns and bridges need to be kept clean, with proper oral hygiene and periodic cleanings, otherwise decay may develop underneath and/or around the margins of the restoration, leading to further dental treatment

(initials)_____

4.DENTURES- COMPLETE OR PARTIAL

The problem of wearing dentures has been explained to me including looseness, soreness, and possible breakage, and relining due to tissue change. Follow-up appointments are an integral part of maintenance and success of a prosthetic appliance. Persistent sore spots should be immediately examined by the doctor.

I further understand that surgical intervention (i.e. tori (bone) removal, bone recontouring, or implants) may be needed for dentures to be properly fitted. I also understand that due to bone loss or other complicating factors, I may never be able to wear dentures to my satisfaction. (initials)_____

5.Endodontic Treatment (Root Canal Therapy):

The purpose and method of root canal therapy have been explained to me, as well as reasonable alternative treatment, and the consequences of non-treatment I understand that the following root canal therapy my tooth wiH be brittle and must be protected against fracture by placement of a crown (cap) over the tooth.

- Post treatment discomfort lasting a few hours to several days for which medication wiH be prescribed if deemed necessary by the doctor.
- Post treatment swelling of the gum area in the vicinity of the treated tooth or fecial swelling, either of which may persist for several days or longer.
- Infection
- Restricted jaw opening
- Breakage of root canal instruments during treatment, which may in the judgment of the doctor be left in the treated root canal or bone as part of the filling material, or it may require surgery for removal.
- Perforation of the root canal with instruments, which may require addKonal surgical treatment or result in premature tooth loss or extraction.
- Risk of temporary numbness in treatment area.

If an "open and medicate" or pulpotomy procedure is performed. I understand that this is not permanent treatment, and I need to pay for, and finish final root canal therapy. If root canal treatment is not finalized I expose myself to infection and/or tooth may have to extracted (initials)_____

6. FILLINGS: I have been advised of the need for fillings, either silver or composite (plastic), to replace tooth structure lost to decay. I understand that with time fillings will need to be replaced due to wearing of material. In cases where very little tooth structure

remains, or existing tooth structure fractures off, I may need to receive more extensive treatment (such as root canal therapy, post and build-up, and crowns), which would necessitate a separate charge.

I understand that the silver amalgam restoration is an acceptable procedure according to the American Dental Association guidelines and, as such, is a treatment used by Tanada-Lee Family Dental Care. The advantages and disadvantages of alternate materials have been explained to me. **(initials)_____**

7.REMOVAL OF TEETH:

I understand that the purpose of the procedure/surgery is to treat and possibly correct my diseased oral tissues. The doctor has advised me that if this condition persists without treatment or surgery, my present oral condition will probably worsen in time. Potential risks include, but are not limited to, the following:

- Possible bone fracture which require wiring or surgical treatment.
- Injury to adjacent teeth, caps, or fillings (requiring the recementation of crowns, replacement of fillings, fabrication of crowns, or extraction), or injury to other tissues not within the described surgical area.
- Residual root fragments or bone spicules left when complete removal would require extensive surgery or needless surgical complications.
- Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.
- Limitation of opening; stiffness of facial and/or neck muscles; change in bite; or temporomandibular joint (jaw joint) difficulty (possibly requiring physical therapy or surgery).
- Post-operative discomfort; swelling; prolonged bleeding; tooth sensitivity to hot or cold; gum shrinkage(possibly exposing crown margins); tooth looseness; delayed healing (dry-socket) and/or infection (requiring prescriptions or additional treatment, i.e. surgery).
- Injury to the nerve underlying the teeth resulting in itching, numbness, or burning of die lip,chin,gums,cheek,teeth,and/or tongue on the operated side: this may persist for several weeks, months, or, in remote instances, permanently.

(initials)_____

8.Pedodontics (Child Dentistry):

I understand that the following procedures are routinely used at Tanada- Lee Family Dental Care, as well as being accepted procedures in the dental profession.

- Positive Reinforcement-Rewarding the child who portrays desirable behavior, by the use of compliments, praise, a pat or hug, and/or token objects or toys.
- **Voice Control-** The attention of a disruptive child is gained by changing the tone or increasing the volume of the doctor's voice.
- **Physical Restraint-** Restraining the child's disruptive movements by holding down their hands, upper body, head, and/or legs by the use of the dentist's or assistant's hand or arm, pr by use of a special device (referred to as a "papoose boar').
- **Nitrous Oxide And/Or Oral Sedation-** Nitrous Oxide is a mild gas that is mixed with oxygen, and is used to sedate a person. It is administered through a mask placed over the child's nose. Oral sedations are medications administered to children to help them relax. With their use the parent/or guardian must be available to escort the child home after the sedation procedure, and observe their behavior throughout the day. **(initials)_____**

I understand that with the use of an injection, used to numb the tooth area for dental procedures, the possibility exists that the child may inadvertently bite their lip causing injury to occur.

I understand the need to return to the office, for evaluation, if swelling and/or pain in my child does not go away after a sufficient period of time.

I understand the need to return to the office within three months following nerve treatment of a "baby tooth" for evaluation, and the possibility of it then needing an extraction.

I UNDERSTAND THAT NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN THAT THE PROPOSED TREATMENT WILL BE CURATIVE AND/OR SUCCESSFUL TO MY COMPLETE SATISFACTION. I AGREE TO COOPERATE COMPLETELY WITH THE RECOMMENDATIONS OF THE DOCTOR WHILE I AM UNDER HER/HIS CARE, REALIZING THAT ANY LACK OF SAME COULD RESULT IN LESS THAN OPTIMUM RESULTS.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE, INCLUDING THE OPPOSING SIDE OF THIS DOCUMENT, AND CONSENT TO THE OPERATION AND EXPLANATION REFERRED TO OR MADE. I HAVE BEEN ENCOURAGED TO ASK QUESTIONS, AND HAVE HAD THEM ANSWERED TO MY SATISFACTION.

I UNDERSTAND THAT TANADA-LEE FAMILY DENTAL CARE PROVIDES DENTAL CARE SERVICES WITHOUT DISCRIMINATION BASED ON RACE, RELIGION, COLOR, NATIONAL ORIGIN, SEX, SEXUAL ORIENTATION, PHYSICAL OR MENTAL DISABILITY

Print Patient's Name_____SIGNATURE:_____

Relationship:_____Date:_____

Doctor:_____ Witness_____

TANADA-LEE FAMILY DENTAL

Case Notes* Payment is due at the time services are render

Regarding Insurance:

We may accept assignment of insurance benefits. However, we do require the above amount to be paid at the time of service. Please be advised this is ONLY an estimate. The balance is your responsibility whether your insurance company pays or not. We are not a party to that contact. Please be aware that some, and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under your dental insurance plan.

Usual and Customary Rates:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

CANCELLATION AND/OR RESCHEDULING:

There will be a fee of $25.00 dollars or more for any appointment that is canceled/ rescheduled or no show with less then 24hours notice. I understand that if I should have to cancel/ reschedule it will have to be with the 24 hours of my appointment time. If I don't there will be a fee added to my account.

Signature _____ Date _____

PATIENT NAME	
PREFERRED NAME	MEDICAL ALERT

DENTAL HISTORY

Welcome! So that we may provide you with the best possible care
please complete both sides of this medical/dental history form.
All information is completely confidential.

What is the reason for your visit today? _____

_____

Date of Last Dental Visit _____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays** _____

What was done at your last dental visit? _____

_____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____

How often do you have dental examinations? _____

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

Have you ever used or are currently using topical fluoride? Yes No

What other dental aids do you use? (Interplak. toothpick, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:		
Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No
If yes. where?		

Do you:		
Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Snore or have any other sleeping disorders?	Yes	No
Smoke/chew tobacco or use other tobacco products?	Yes	No

Have you ever had:		
Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No
If so. please describe, including cause		

Have you experienced:		
Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No
If so, what is your biggest concern?		
Have you ever had an upsetting dental experience?	Yes	No
If yes, please describe		

Have you ever been told to take a pre-medication prior to dental treatment? Yes No

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

(Please complete other side)

PATIENT NAME	MEDICAL HISTORY
PREFERRED NAME	MEDICAL ALERT

1. Physician's Name _____ Phone ( ) _____
   Have you had any medical care within the past two years? ..... Yes No
   Describe ----------
2. Have you taken any medication or drugs during the past two years? ..... Yes No
3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? ..... Yes No
   If yes, please list name and dosage _____ _____
4. Have you ever taken prescription medications for weight loss (diet pills)? ..... Yes No
   If yes, did you take any of the following? (circle if yes) Fen-Phen Pondimen Redux Other
   If yes to any of the above, did you have a medical exam for heart issues? ..... Yes No
5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel,Boniva or other similar drugs? ..... Yes No
6. Are you aware of having an allergic **(or adverse)** reaction to any substanceor medication? ..... Yes No
   If yes, please specify .....
7. Have you been a patient in the hospital during the past five years? ..... Yes No
8. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)...	Yes	No	Ulcers.....	Yes	No	Hepatitis ABC (circle)...	Yes	No
Chest Pain.....	Yes	No	Diabetes.....	Yes	No	Venereal Disease.....	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems.....	Yes	No	A.I.D.S./H.I.V. Positive.....	Yes	No
Heart Murmur.....	Yes	No	Glaucoma.....	Yes	No	Cold Sores/Fever Blisters.....	Yes	No
High/Low Blood Pressure.....	Yes	No	Contact lenses.....	Yes	No	Blood Transfusion.....	Yes	No
Mitral Valve Prolapse.....	Yes	No	Emphysema.....	Yes	No	Hemophilia.....	Yes	No
Artificial Heart Valve/Pacemaker.....	Yes	No	Chronic Cough.....	Yes	No	Sickle Cell Disease.....	Yes	No
Rheumatic Fever.....	Yes	No	Tuberculosis.....	Yes	No	Bruise Easily.....	Yes	No
Arthritis/Rheumatism.....	Yes	No	Asthma.....	Yes	No	Liver Disease/Yellow Jaundice..	Yes	No
Cortisone Medicine.....	Yes	No	Hay Fever/Allergy/Hives.....	Yes	No	Neurological Disorders.....	Yes	No
Swollen Ankles.....	Yes	No	l atex Sensitivity	Yes	No	Epilepsy or Seizures.....	Yes	No
Stroke.....	Yes	No	Sinus Trouble.....	Yes	No	Fainting or Dizzy Spells.....	Yes	No
Diet (Special/Restricted).....	Yes	No	Radiation Therapy.....	Yes	No	Nervous/Anxious.....	Yes	No
Artificial Joints (hip, knee, etc.)....	Yes	No	Chemotherapy.....	Yes	No	Psychiatric/Psychological Care..	Yes	No
Kidney Trouble.....	Yes	No	Tumors.....	Yes	No			

9. Have you lost or gained more than 10 pounds in the past year? ..... Yes No
10. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No
    If yes, please list: ----------
11. **Women:** Are you pregnant or think you could be pregnant? Yes _____Months No **Nursing?** Yes No
12. Do you use birth control prescriptions? ..... Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date____ _____ _____ .

History Review

Dentist Signature _____ Date____ _____ _____ .