PARKER DENTISTRY

info@theladeraranchdentist.com 949.429.0049
777 Corporate Dr. Suite 100 Ladera Ranch, CA

Submit via Email

Patient Information

Date _____

Our passion is to provide you with a totally different experience. Giving you the results you are seeking with better communication and treatment options. **We are creators of new lifestyles through smiles.**

___Dr.___Mr.___Mrs.___Ms.___Miss

Name _____ I prefer to be called _____

Person Responsible For Account _____

Home Address _____ City_____ Zip_____

Marital Status: ___Single ___Married ___Separated ___Widow(er)

Home Phone _____ Work Phone _____ Cell _____

Birth date _____ Soc. Sec #_____ Drivers Lic. #_____

Email _____

Where do you prefer to receive calls? _____

What is your occupation? _____ Employer _____

Name of Spouse or Parent if Minor _____

If Patient is a minor, Mother & Father's names & birthdates:

_____

In case of emergency who should we contact?

Name _____ Phone _____ Relation _____

Do you have dental insurance? ___Yes ___No If Yes, which carrier? _____

Insured member's name _____ DOB _____ SS# _____

Employer _____ Company Address _____

Phone _____ Group # _____ Policy #_____

Do you have secondary insurance coverage? _____

How did you hear about our office? ___Internet search ___Online Reviews ___Print Media ___Personal Referral

Personal Referral: If so, whom may we thank? _____

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Health History

Date of last physical _____

Name of personal physician _____ Phone # _____

How do you assess your current health? ____Excellent ____Good ____Fair ____Poor

Are you currently under the care of a physician? ___Y___N If yes, why? _____

Please mark any that apply:

AIDS/HIV	Yes	Heart Murmur	Yes	Tuberculosis	Yes		
Anemia	Yes	Heart Problems	Yes	Tumor/Growth in head	Yes		
Arthritis, Rheumatism	Yes	Hepatitis Type _____	Yes	Ulcer	Yes		
Artificial Heart Valves	Yes	High Blood Pressure	Yes	Sleep Apnea	Yes		
Artificial Joints	Yes	Kidney Disease	Yes				
Asthma	Yes	Liver Disease	Yes	Headaches	Yes		
Bleeding abnormally	Yes	Mitral Valve Prolapse	Yes	Jaw Pain	Yes		
Blood Disease	Yes	Nervous Problems	Yes	Jaw Popping	Yes		
Cancer	Yes	Pacemaker	Yes	Limited Opening	Yes		
Chemotherapy	Yes	Psychiatric Care	Yes	Congested Ears	Yes		
Circulatory Problems	Yes	Radiation Treatment	Yes	Posture Problems	Yes		
Cortisone Treatments	Yes	Rheumatic Fever	Yes	Clenching	Yes		
Cough, persistent	Yes	Scarlet Fever	Yes	Grinding	Yes		
Depression	Yes	Sinus Trouble	Yes	Facial Pain	Yes		
Diabetes	Yes	Stroke	Yes	Neck Ache	Yes		
Epilepsy	Yes	Swollen Feet or Ankles	Yes	Bell's Palsy	Yes		
Fainting or dizziness	Yes	Swollen Neck Glands	Yes				
Glaucoma	Yes	Thyroid Problems	Yes				
Heart Lesions	Yes	Tonsillitis	Yes				

Please list any allergies: _____

Have you taken or currently taking medications for osteoporosis known as bisphosphonates for example Fosamax, Actonel, or Boniva? ___Y___N If yes, medication _____

Do you smoke or use chewing tobacco? How much? For how long? _____

Have you seen a ___Chiropractor ___Neurologist ___Massage Therapist ___ENT

Are you currently taking prescription medications? If yes, please list below (name and purpose)

_____

_____

Do you snore, use a CPAP or have had a sleep study? If yes, please describe:

_____

Insomnia ___Y___N Less than 7 hours sleep/night? ___Y___N How many times do you get up at night?_____

Height _____ Neck Circ _____

Women: Are you pregnant? ___Y___N (Expected Delivery Date _____)

Women: Are you taking birth control pills? ___Y___N Breastfeeding? ___Y___N

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Dental History

If you could wave a wand and change anything you could about the appearance of your smile, what would you want different?

_____

_____

The date of your last dental visit _____ Previous Dentist _____

City, State _____ Phone _____

Have you ever had a less than positive dental experience? ☐ Y ☐ N If so, please explain _____

_____

_____

Have you seen an Orthodontist, had your bite adjusted, or treated for TMJ? _____

What is the most important thing to you about your future smile and dental health? _____

_____

What is the most important thing to you about your visit today? _____

_____

If you would whiten your teeth for a cost anyone could afford, would you do it? _____

Have you professionally whitened before? ☐ Y ☐ N

Please check any of the following that applies to you:

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, ear aches, neck pain
- ☐ Mouth ulcers or cold sores
- ☐ Broken tooth or fillings
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifting teeth
- ☐ Bad breath or bad taste in your mouth
- ☐ Jaw joint pain
- ☐ Clicking, popping in jaw joint
- ☐ Muscle pain in the jaw, temple region, neck area

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Importance of my overall health?

1 2 3 4 5 6 7 8 9 10

Importance of preventive care to me?

1 2 3 4 5 6 7 8 9 10

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

What other dental aids do you use? (Electric tooth brush, Water-Pik, Toothpicks, Soft-Picks, etc.) _____

Signature _____ Date _____

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CONSENT TO DENTAL PHOTOGRAPHY

I, _____ (Patient), authorize Parker Dentistry

Dr. Lincoln Parker DMD, to take photographs, and/or videos of my face, jaws and teeth, before, during and after treatment.

I consent to allow the photographs to be used for the following:

- *Dental Records*
- *Dental Research*
- *Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books*
- *Marketing material, including websites and printed materials, patient education*

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs.

☐ Check here if you do not want your full face shot used for any of the above purposes

Signature (Patient) _____

Date _____

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Financial Guidelines

We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, and Discover. Outside financing is available upon request and approval.

Please check if you would like more information about financing options. ☐

Please note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges incurred.

Do you have insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- 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.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, credit card at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office.

Signature _____ Date _____

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Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of this office's Notice of Privacy Practices.

Signature _____ Date _____

You may refuse to sign this acknowledement

Refusing _____ Date_____

HIPAA Release of Information

I, _____, authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

- ☐ Spouse _____
- ☐ Child(ren)_____
- ☐ Other _____
- ☐ Information is not to be released to anyone

This release of information will remain in effect until terminated by me in writing.

Messages

Please call ___ My home ___ My work ___ My cell

If unable to reach me:

- ☐ You may leave a detailed message
- ☐ Please leave a message asking me to return your call

The best time to reach me is (day) _____ between (time)_____

Signature _____ Date _____

Witness _____ Date _____