

**H A L E S P A R K E R**  
D E N T I S T R Y

info@theladeraranchdentist.com

949.429.0049

777 Corporate Dr. Suite 100 Ladera Ranch, CA

**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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### **Airway and Sleep Questionnaire**

This form is to help assess the risks of a narrow airway or jaw development.

Have you been diagnosed with sleep apnea?	Yes
Are you happy with your CPAP or sleep appliance?	Yes
Do you wake at night to go to the restroom?	Yes
Do you wake feeling tired and unrested?	Yes
Do you habitually snore?	Yes
Do you have Hypertension/High Blood Pressure?	Yes
Do you wake with a headache?	Yes
Do you experience daytime drowsiness/fatigue?	Yes
Do you have blocked nasal passages?	Yes
Has anyone observed you stop breathing in sleep?	Yes
Do you ever wake choking or gasping?	Yes
Do you grind your teeth while sleeping?	Yes
Is your neck circumference greater than 15.75"?	Yes
Is your Body Mass Index (BMI) more than 35?	Yes

Airway, TMJ, and function are related. Thank you for taking the time to fill out this form in addition to the other forms. The final sheets are simple consents/agreements. Please ask for help or assistance if forms need to be provided.

**CONSENT TO DENTAL PHOTOGRAPHY**

I, \_\_\_\_\_(Patient), authorize Hales Parker Dentistry

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 acknowledgement\*

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 \_\_\_\_\_