Patient Screening Form

ADA

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.

Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: *Last* *First* *Middle*
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )

Address: *Mailing address*
City: State: Zip:

Occupation: Height: Weight: Date of Birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: *Include area code* ( ) Cell Phone: *Include area code* ( )

If you are completing this form for another person, what is your relationship to that person?
Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the the question)*

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? *Circle one:* DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐
Physician Name: Phone: *Include area code* ( )			
Address/City/State/Zip:			
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐
If yes, what condition is being treated?			
Date of last physical exam:			

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐
If yes, what was the illness or problem?			
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐
If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:			

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Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? *Circle one:* VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink i n a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐

	Yes	No	DK
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: _____			
Recurrent Infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation:

Phone: *Include area code*
( )

	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐

Please explain:

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments:

KINGS BEACH DENTAL

Acknowledgement of Receipt of Notice Privacy Practices

- You May Refuse to Sign This Acknowledgement

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

Print Name: _____

Signature: _____ Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refuse to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

KINGS BEACH DENTAL

Agreement to Receive Electronic Communication

Patient Name:_____ Date of Birth:_____

I agree that the dental practice may communicate with me electronically at the email address below:

Email Address:_____

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address.

I can withdraw my consent to electronic communications by calling:
530-546-5678 or by email : kingsbeachdental@gmail.com

_____ _____

Patient Signature Date

JASON HENDERSON D.M.D, A PROFESSIONAL CORPORATION

PATIENT CONSENT/ACKNOWLEDGMENT FORM

By signing below, you consent to the use and disclosure of your protected health information by Jason Henderson, our staff, and our business associates for treatment, payment and health care operations. For more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practice ("Notice"). You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If terms do change, you may obtain a revised Notice simply contacting this office at (530)546-5678 and requesting a revised Notice. We will also post any revised notice in the front office.

You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose our Protected Health Information (PHI).

THIS FORM IS ALSO USED TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF **OUR NOTICE OF PRIVACY PRACTICES** OR TO DOCUMENT OUR GOOD FAITH EFFORT TO OBTAIN THAT ACKNOWLEDGEMENT.

I HAVE REVIEWED, UNDERSTAND AND AGREE TO THE CONTENT OF THE NOTICE OF PRIVACY.

Name: _____ Date: _____

PLEASE SPECIFY THE EXACT REASON WHY PATIENT CHOSE NO TO SIGN THE CONSENT/**ACKNOWLEDGEMENT** OF NOTICE OF PRIVACY.

_____

_____

_____

ALL FORMS ARE FOR EDUCATIONAL USE ONLY AND DO NOT CONSTITUTE LEGAL ADVICE. ALL FORMS ARE SUBJECT TO CHANGE IN THE FEDERAL LAW AND APPLICABLE STATE LAWS. SEEK LEGAL ADVICE BEFORE USE.

Office Policies

Jason Henderson, D.M.D.
A Professional Corporation

To our patients,

Our philosophy is to provide the highest quality of patient education and dental care to all of our patients. To ensure that you begin with a positive experience we have prepared the following information for you to review. Should you have any questions please feel free to let us know.

* If you have dental insurance we would be happy to file your dental claims and accept the insurance portion directly from your insurance company provided that payment is received from them within 60 days. We ask that you familiarize yourself with your insurance plan benefits, and provide us with the correct information for the submittal of your dental claims. For your convenience, we will provide you with an estimate for your dental care after a treatment plan has been completed for you. However, the insurance estimate is not a guarantee of payment. Please remember that your insurance is a contract between you, your employer, and the insurance company. Not all services are covered benefits in all dental insurance contracts; therefore, you are ultimately responsible for the total amount of your dental fees. The treatment recommended for you is indicated regardless of your dental insurance benefits, deductibles, limitations or maximums.

_____
Initials

* In order to keep our fees to you as low as possible, we ask that you pay all co-payments from insurance and all treatment fees at the time of service. If payment is not made upon completion of your appointment, we charge 1.5 % APR on any account that is more than 60 days outstanding. We are happy to pass our savings for administrative costs on to you. There will be a $15 charge per patient, per visit due to the costs of personal protective equipment (PPE) related to the COVID-19 pandemic.

_____
Initials

*If you are unable to keep your appointment that has been reserved for you, **we request that you provide us with a 48 hours' advance notice.** Failed or cancelled appointments with less than 48 hr. notice are subject to a $60.00 charge.The earlier you are able to notify us we will be able to provide you with another appointment to ensure that you get the time you prefer, and we can also invite another patient in for their care. We realize that emergencies do occur and we will be flexible under those circumstances.

_____
Initials

*For your safety and conjunction with HIPPA, we ask that you provide us with the names of any person that we may leave a detailed message with regarding your appointments, pre-medications, and or any other important information pertaining to your oral and overall health. Also, allowing us to leave a detailed message on your phone machine. Please list names below:

_____

_____
Initials

* For your convenience, we have listed the methods of payment that we accept. Please identify which form of payment is most convenient for you to use for payment of your dental care.

_____-Cash or Check

_____-Visa/Master Card/ Care Credit

_____-Care Credit payment plans available upon approval.

_____ _____
Signature Date

TREATMENT CONSENT

TREATMENT TO BE DONE
I understand and consent to have any treatment done by the Dentist after the procedure, risks, benefits and costs have been fully explained. These treatments include, but are not limited to x-rays, cleanings, periodontal treatments, fillings, crowns, bridges, extractions, root canals, and/or dentures.

DRUGS AND MEDICATION
I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock.

CHANGES IN THE TREATMENT PLAN
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. For example, root canal therapy following routine restorative procedures. I give permission to the Dentist to make any/all changes and additions as necessary.

REMOVAL OF TEETH
I understand that there are alternatives to tooth removal (root canal therapy, crowns, and periodontal surgery, etc.) And I agree to completely understand these alternatives, including their risk and benefits prior to authorizing the Dentist to remove teeth and others necessary for reasons as above. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling my teeth, lips, tongue and surrounding tissue that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.

CROWNS (CAPS) AND BRIDGES
Preparing a tooth may irritate the nerve tissue in the center of the tooth, leaving your tooth feeling sensitive to heat, cold or pressure. Treating such irritation may involve using special toothpastes or mouth rinses or root canal therapy. I understand that sometimes it is not possible to match the color of natural teeth exactly with artifical teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be *careful to ensure that they are kept on until the permanent crowns are delivered.* It is my responsibility to return for the permanent cementation within 20 days from tooth preparation, as excessive delays may allow for tooth movement, which may necessitate a remake of the crown, bridge or cap. I understand there will be additional charges for remakes due to my delaying permanent cementation and I realize that final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before permanent cementation.

ENDODONTIC TREATMENT (ROOT CANAL)
I understand that there is no guarantee that root canal treatment will save a tooth, and the complications can occur from the treatment, and that occasionally root canal filling materials may extend through the tooth, which does not necessarily effect the success of the treatment. I understand that endodontic files and drills are very fine instruments and stresses vented in their manufacture and calcification present in teeth can cause them to break during use. *I understand that referral to an endodontist for additional endodontic treatments may be necessary following any root canal treatment,* and I agree that I am responsible for additional costs for treatment performed by the Endodontist. I understand that a tooth may require extraction in spite of all efforts to save it.

PERIODONTAL DISEASE
I understand that periodontal disease is a serious condition causing gum and bone inflammation and/or loss and that it can lead to the loss of my teeth. I understand the alternative treatment plans to correct periodontal disease, including gum surgery, tooth extractions with or without replacement. I understand that undertaking any dental procedures may have future adverse effect on my periodontal condition.

FILLINGS
I understand that care must be exercised in chewing on fillings, especially during the first 24 hours to avoid breakage. I understand that a more extensive filling or a crown may be required, as additional decay or fractures may become evident after initial excavation. I understand that significant sensitivity is a common, but usually temporary, after effect of a newly placed filling. I further understand that filling my tooth may irritate the nerve tissue cerating sensitivity and treating such sensitivity could require root canal therapy.

DENTURES
I understand that wearing of dentures can be difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate dentures *(placements of a denture immediately after extractions)* may be painful. Immediate dentures may require considerable adjusting and several relines. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of more than 30 days, there will be additional charges. A permanent reline will be needed later, which is not included in the denture fee. I understand that all adjustments are included in the denture fee for a period of six months from the date of delivery, and that any and all adjustments of alterations of any kind after this initial period are subject to charges.

I have received and read a copy of the Dental Board Of California's Dental Materials Fact Sheet.

I understand that dentistry is not an exact science and that no dentist can properly guarantee results.

I hereby authorize any of the doctors or dental auxiliaries to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fee , or court costs that may be incurred to satisfy an obligation to this office.

Patient or Parent/Guardian Signature _____ Date _____

Doctor Signature _____ Date _____