

W E L C O M E

PATIENT INFORMATION

DENTAL INSURANCE

Date _____

SS/HIC/Patient ID # _____

Patient _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex M F Age _____

Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to

Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date Relationship to Patient

PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext _____ Cell Phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath Yes No

Bleeding gums Yes No

Blisters on lips or mouth Yes No

Burning sensation on tongue Yes No

Chew on one side of mouth Yes No

Cigarette, pipe, or cigar smoking Yes No

Clicking or popping jaw Yes No

Dry mouth Yes No

Fingernail biting Yes No

Food collection between the teeth Yes No

Foreign objects Yes No

Grinding teeth Yes No

Gums swollen or tender Yes No

Jaw pain or tiredness Yes No

Lip or cheek biting Yes No

Loose teeth or broken fillings Yes No

Mouth breathing Yes No

Mouth pain, brushing Yes No

Orthodontic treatment Yes No

Pain around ear Yes No

Periodontal treatment Yes No

Sensitivity to cold Yes No

Sensitivity to heat Yes No

Sensitivity to sweets Yes No

Sensitivity when biting Yes No

Sores or growths in your mouth Yes No

How often do you floss? _____

How often do you brush? _____

MEDICATIONS

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

- | | | | | | |
|--|--|-----------------------|--|---------------------------------|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding abnormally, with extractions or surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Lesions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or growth on head or neck | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, persistent or bloody | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diet Pills (Phen-Fen) History | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | Radiation Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Do you wear contact lenses? Yes No

Women:

Are you pregnant? Yes No

Due date _____

Are you nursing? Yes No

Taking birth control pills? Yes No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

- | | |
|--|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Barbiturates (Sleeping pills) | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Latex | _____ |

NOTES:

CONSENT:

The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) _____

and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that 18% annually will be added to any balance over 60 days. In the event of default I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

Dr. Signature: _____ Date _____

F.D. Fores, D.M.D. SMILE EVALUATION FORM

Name: _____ **Date:** _____

Doctor's Notes:

Hold a face mirror 12"-14" from your face. Smile to show your teeth; take the time to observe your teeth carefully. Then answer the following questions. (It is helpful to have a friend ask you the questions.)

TREATMENT OPTIONS

1. Do you like the appearance of your teeth; your smile? Yes No
If not, explain _____

2. Are your teeth all in alignment (straight)? Yes No
If not, explain _____

3. Do you have spaces that you don't like? Yes No
If not, explain _____

4. Do you like the color of your teeth? Yes No
If not, explain _____

5. Do you like the shape of your teeth? Yes No
If not, explain _____

6. Are your teeth...
Chipped? _____ Protruding? _____ Hidden? _____

7. Are your teeth wearing on the biting surfaces? Yes No
If yes, explain _____

8. Are there old fillings or dental work you don't like looking at? Yes No
If not, explain _____

9. What would you like to change the most in the appearance of your teeth?

10. How would you like your teeth to look?

Name: _____ Medical Alert: _____ Date: _____

EXISTING REST: TX WORK TO BE DONE

1.		PROPHY - SGC - ROOT PLANNING FL - CPE
2.		PERIODONTITIS - MODERATE - MILD - SEVERE
3.		FUD - FLD
4. (A)		PUD - PLD
5. (B)		RELIN UPPER LOWER
6. (C)		
7. (D)		
8. (E)		OVERDENTURE • MAX MAND
9. (F)		OVERDENTURE ABUTMENTS:
10. (G)		TOOTH # IMPLANT #
11. (H)		TYPE OF OVERDENTURE ATTACHMENTS
12. (I)		
13. (J)		
14.		ORTHODONTICS
15.		CLASSIFICATION OF MALOCCLUSION
16.		CLI _____ CLII _____ CLIII _____
17.		
18.		
19.		IMPLANTS: TYPE:
20. (K)		
21. (L)		
22. (M)		SUBPERIOSTEAL (U) _____ (L) _____
23. (N)		UNILATERAL UNIVERSAL
24. (O)		SOFT TISSUE EXAMINATION
25. (P)		
26. (Q)		BUCCAL VESTIBULES (U) _____ (L) _____
27. (R)		FLOOR OF MOUTH & TONGUE _____ PALATE _____ TONSILS _____ THROAT _____
28. (S)		SPECIAL REMARKS
29. (T)		
30.		
31.		
32.		CANCER SCREENING <input type="checkbox"/> YES <input type="checkbox"/> NO

Charted By: _____

Dr. Francisco D. Fores, D.M.D.

P210A

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

NOTICE APPLIES TO

This Notice describes the practice of this office and those of:

- Any healthcare professionals authorized to enter information into your record;
- All employees, staff, and other office personnel; and
- Any volunteers, interns, or students we allow to work with you while you are a patient of this Medical Practice.

This notice applies to all facilities and entities owned, operated and/or managed by this office. A complete listing of facilities and entities operating under this notice may be obtained by contacting the Privacy Officer

THE DUTIES OF THIS OFFICE/ORGANIZATION

This office/organization is required by law to maintain the privacy of your personal medical information and to provide you with notice of our legal duties and privacy practices with respect to that information. We are also required to abide by the terms of our current Notice of Privacy Practices.

USE AND DISCLOSURE OF MEDICAL INFORMATION

This office/organization may use your medical information for treatment, payment, and healthcare operations purposes. The following are some examples:

- For treatment purposes, we may release your medical information to other physicians, dentists, or health care providers, such as nurses or technicians, to assist in treating you.
- In billing for your treatment, we may release your medical information to your insurance company in filing a claim or in order to receive payments.
- We may also use your medical information for our healthcare operations. This includes activities involving review of our treatment and services to help us evaluate the quality of care we are providing, and evaluation of the performance of our staff in caring for you.

APPOINTMENT REMINDERS, CALL BACKS, & TREATMENT ALTERNATIVES

We may use your information to contact you for appointment reminders, to call you with the results of diagnostic tests, or to check on your condition following a visit or procedure. We may also contact you to provide you with information about treatment alternatives or health-related benefits or services.

FUNDRAISING

We may use your information to contact you in an effort to raise money for this organization and its operations.

OTHER DISCLOSURES

There are some disclosures of medical information that do not require your authorization. Those disclosures include any of the following:

- Those required by federal, state or local law;
- To report adverse events or defects associated with products or medications;

Dr. Francisco D. Fores, D.M.D.

P210B ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE	
Name:	Home Phone:
Address:	City/State/Zip:
I have recieved the Notice of Privacy Practices	
Signature: _____ Date: _____ Patient/Spouse/Financially Responsible Party	
Relationship, if other than Patient: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Guardian <input type="checkbox"/> Other: (specify):	
<input type="checkbox"/> Patient refuses, or is unable, to acknowledge receipt of the Notice of Privacy Practices.	
Employee Signature: _____ Date: _____	

Note: The information on this form may be combined with any of the following:

- Restrictions on Disclosure of Information
- Use of Alternative Methods or Locations for Confidential Communications
- Family Members/ Friends Involved in a Patient's Care