SMILES ON BRISTOL DENTISTRY

2502 S. BRISTOL ST. SANTA ANA, CA 92704
SMILESONBRISTOL@GMAIL.COM
PHONE (714) 662-2000
WWW.SMILESONBRISTOLDENTAL.COM

MEDICAL HISTORY

IF YOU ANSWER YES TO EITHER OF THE TWO QUESTIONS BELOW, PLEASE STOP AND RETURN THIS FORM TO THE RECEPTIONIST.

HAVE YOU HAD THE FOLLOWING DISEASES OR PROBLEMS?

ACTIVE TUBERCULOSIS ☐ YES ☐ NO COUGH THAT PRODUCES BLOOD ☐ YES ☐ NO

THE FOLLOWING QUESTIONS ARE FOR YOUR BENEFIT AND ASSURE THAT TREATMENT WILL TAKE INTO CONSIDERATION YOUR PAST AND PRESENT HEALTH STATUS. SOME QUESTIONS MAY SEEM UNRELATED TO YOUR DENTAL CONDITION, BUT THEY ARE ALL ASSOCIATED WITH PROPER ORAL HEALTH CARE. PLEASE ANSWER EACH QUESTION.

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 dosages of aspirin? ..... Yes No
   If yes, please list name and dosage_____
4. Are you sensitive or allergic to any substance or medication? ☐ Yes ☐ No If yes, which drugs? ☐ Penicillin ☐ Tetracycline
   ☐ Sulfa Drugs ☐Aspirin ☐ Codeine ☐Other. If other, what drugs? _____
5. Have you ever taken prescription medications for weight loss (diet pills)? ..... Yes No
   If yes, did you take any of the following: ☐Fen-Phen ☐Pondimen ☐Redux ☐Other_____
6. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? ..... Yes No
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:

A.I.D.S./H.I.V. Positive ..... Yes No	Diabetes ..... Yes No	Liver Disease/Yellow Jaundice ..... Yes No
Anemia ..... Yes No	Diet (Special/Restricted) ..... Yes No	Mitral Valve Prolapse ..... Yes No
Arthritis/Rheumatism ..... Yes No	Difficulty Swallowing ..... Yes No	Nervous Disorders ..... Yes No
Artificial Heart Valve/Pacemaker ..... Yes No	Drug Addiction ..... Yes No	Nervous/Anxious ..... Yes No
Artificial Joints ..... Yes No	Emphysema ..... Yes No	Neurological Disorders ..... Yes No
Artificial Prosthesis ..... Yes No	Epilepsy or Seizures ..... Yes No	Osteoporosis ..... Yes No
Asthma ..... Yes No	Excessive Bleeding ..... Yes No	Psychiatric/Psychological Care ..... Yes No
Blood Disease ..... Yes No	Fainting or Dizzy Spells ..... Yes No	Radiation Therapy ..... Yes No
Blood Transfusion ..... Yes No	Glaucoma ..... Yes No	Rheumatic Fever ..... Yes No
Bruise Easily ..... Yes No	Hay Fever/Allergy/Hives ..... Yes No	Scarlet Fever ..... Yes No
Cancer, Tumors, Growths ..... Yes No	Head Injuries ..... Yes No	Sickle Cell Disease ..... Yes No
Cerebral Palsy ..... Yes No	Heart (Surgery, Disease, Attack) ..... Yes No	Sinus Trouble ..... Yes No
Chemotherapy ..... Yes No	Heart Failure ..... Yes No	Stroke ..... Yes No
Chest Pain ..... Yes No	Heart Murmur ..... Yes No	Swollen Ankles ..... Yes No
Chicken Pox ..... Yes No	Hemophilia ..... Yes No	Thyroid Problems/Disease ..... Yes No
Chronic Cough ..... Yes No	Hepatitis A B C (circle)..... Yes No	Tonsillitis ..... Yes No
Cold Sores/Fever Blisters ..... Yes No	Herpes ..... Yes No	Tuberculosis ..... Yes No
Congenital Heart Lesions ..... Yes No	High/Low Blood Pressure ..... Yes No	Ulcers ..... Yes No
Contact Lenses ..... Yes No	Kidney Trouble/Disease ..... Yes No	Venereal Disease ..... Yes No
Cortisone Medicine ..... Yes No	Latex Sensitivity ..... Yes No	Other (Please list below) 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, please list:_____

11. Are you pregnant or think you could be pregnant? Yes _____ Months No Nursing? Yes No
12. Do you use birth control prescriptions? .. .. Yes No
13. Do you have any problems associated with your menstrual period? ..... Yes No

I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient/Guardian Signature_____ Date_____

INITIAL HISTORY REVIEW BP _____ Pulse_____

Dentist Signature_____ Date _____

Year 2	Date _____ Signature_____ Changes in Health_____	Date _____ Pulse_____ Reviewed By_____ DDS
Year 3	Date _____ Signature_____ Changes in Health_____	Date _____ Pulse_____ Reviewed By_____ DDS

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DENTAL HISTORY

PATIENT NAME_____

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

What is the reason of 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 Name_____ Telephone_____

Address_____ City_____ State_____ Zip_____

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 you currently using topical fluoride? YES NO

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

Do you have any dental problems right 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 get cold cores, blisters, or any other mouth 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 get caught between your teeth?	Yes	No

Do You...?

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your cheeks, lips or fingernails regularly?	Yes	No
Hold foreign objects with your teeth?	Yes	No
(pencils, pipe, pins, nails, etc)	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
Drink coffee or tea?	Yes	No

Have you ever had...?

Orthodontic Treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal Treatment?	Yes	No
Your teeth ground or bite adjusted?	Yes	No
A full/partial denture or mouth guard?	Yes	No
How old is it?_____		
A serious injury to the mouth or head?	Yes	No
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 mouth?	Yes	No
Headaches, neckaches, shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

If you could change your teeth:

Whiter?	Yes	No
Straighter?	Yes	No
Remove space?	Yes	No
Replace metal fillings w/ white tooth colored fillings?	Yes	No
Repair chipped teeth?	Yes	No
Replace missing teeth?	Yes	No
Replace old crowns that don't match?	Yes	No
Less gums showing?	Yes	No

Are you satisfied with your teeth appearance?	Yes	No
Do you think your dental health affects your overall health?	Yes	No
Do you think regular professional cleanings are important?	Yes	No

Do you feel nervous about having dental treatment? Yes No

If so, what's your biggest concern?_____

_____

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

_____

_____

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PATIENT NAME: _____ CHART NO: _____

1. a. **ARBITRATION**
Arbitration is the final process for the resolution of any dispute or controversy between a patient, or a personal representative of the patient, as the case may be, and Smiles on Bristol Dentistry concerning the quality of patient services provided to a patient under this agreement for any dispute or controversy concerning the construction, interpretation, performance or breach of this agreement. By entering into this agreement, the patient agrees that such disputes shall be submitted to binding arbitration under the appropriate rules of the American Arbitration Association (AAA).

I. Patient understands and agrees that any and all disputes between patient and Smiles on Bristol Dentistry or its providers shall be resolved by submission to binding arbitration conducted by the AAA. Such Disputes or controversies include, but are not limited to, complaints concerning the quality necessity or outcome of services provided pursuant to this informed Consent Form, as well as the construction, interpretation, performance or breach of the terms of this informed consent Form.

II. Patient further recognizes that by consenting to binding arbitration, patient is giving up the right to have such disputes decided in a court of law and/or before a jury. A declaration of a court or other tribunal of competent jurisdiction that any portion of this agreement to arbitrate is void or unenforceable shall not render any other provision hereof void or unenforceable.

b. **INITATION OF ARBITRATION**
Arbitration can be initiated by flling a demand for arbitration with the AAA, lacated at 225 Bush Street, 18th Floor, San Francisco, CA 94104-4207, telephone number (415) 981-3901. A demand form may be obtained from the AAA.

c. **COSTS**
In all arbitration matters submitted to the AAA, the party initiating demand for the arbitration shall advance all administrative fees connected therewith.

d. **LOCATION**
Arbitration proceedings shall occur in the country where the patient's treatment was performed, unless all parties to the arbitration otherwise agree in writing.

e. **FORM OF DICISION**
The parties agree that the arbitrators shall issue a written opinion. The award of the arbitrators shall be binding and may be enforced in any court having jurisdiction thereof by filling a petition of enforcement of said award. The arbitrator's award shall be accompanied by a writen decision explaining the facts and reasons upon which the award is based, including the findings of fact and conclusions of law made and reached by the arbitrator.

2. **WORK TO BE DONE:** I Understand that the following procedures may be performed on me as part of my dental treatments: X-rays, Fillings, Bridges, Crowns, EXtractions, Impacted Teeth Removal, Root Canals, Dentures, Partial Dentures, Periodontal Treatments and possible other dental treatments.

3. **FILLINGS:** Fillings are procedures in which the dentist removes decayed tooth structure or a faulty restoration and replaces it with Composite Resin or Silver Amalgam fillings. I understand that these procedures could cause the teeth to be sensitive to hot and cold as well as chewing. The majority of the time, these sensitivities are temporary and they will go away within one (1) or two (2) weeks. however, there are times that due to the depth of the filling in the tooth, the pulp or the nerve of the tooth becomes irreversibly sensitive. In these cases, the tooth will need to be treated for root canal therapy and might possibly require a post and a crown to be fully restored. I understand that the dentist can not guarantee that the teeth receiving fillings will not need to receive the above mentioned additional procedures and that I will be responsible for payments for any additional treatments needed to restore the teeth, if the initial filling procedure does not correct the problem.

4. **DRUG AND MEDICATIONS:** I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, vomiting and/or anaphalcctic shock (severe allergic reaction).

5. **CHANGES IN TREATMENT PLAN:** I understand that during treatment it may be necessary to change procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the Dentist to make those changes as necessary.

6. **REMOVAL OF TEETH:** Alternatives to removal have been explained to me (root canal therepy, crowns and periodontal surgery, etc.) and I authorize the Dentist to remove the teeth outlined in the treatment plan and any others necessary under paragraph #5. 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 risk involved in having teeth removed, some of which are pain, swelling, spread of infection,dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Parasthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment.

7. **ANESTHESIA:** I realize the risks involved in receiving a local anesthetic, some of which are facial paralysis, inflamed tissue, adverse reactions to drugs causing cardiac arrest, miscarriage, hemorrhage, nerve damage and/or numbness. I also understand in rare instances patients may have allergic reactions to anesthetic, which may require emergency medical attention, or find that anesthesia reduces the ability to control swallowing, which increases the chance or swallowing foreign objects during treatment.

8. **CROWNS, BRIDGES AND CAPS:** I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temportary 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, and that if I don't have the permanent crown(s) placed, permanent serious damage or loss of the tooth/teeth involved may ensue, and that if i delay placement I may cause the teeth involved to move making the permanent crown not fit properly. I also understand the lower edge of a crown is usually designed to rest near the gumline, which may increase the chance of gum irritation, infection, or decay. Proper brushing and flossing at home, a healthy diet and regular professional cleanings are essential to help prevent these problems.

INFORMED CONSENT

9. **DENTURES - COMPLETE OR PARTIAL:** I realize that full or partial dentures are artificial constructed of plastic, metal and/or porcelain. The problem of wearing these appliances have been explained to me including looseness, soreness, and possible breakage , and relining due to tissue and bone change.
10. **ENDODONTIC TREATMENT (ROOT CANAL):** I realize there is no guarantee that root canal treatment will save my tooth, and that complication can occur fromtreatment. Occasionally a root canal instrument will break off in a root canal that is twisted, curved or blocked with calcium deposits. Depending on its location, the fragment can be retrieved or it may be necessary to seal it in the root canal (these instruments are made of sterile, non-toxic surgical steel, so this causesno harm). It may also be necessary to perform an apicoetomy to seal the root canal. As a result of filing in the root canal, the incomplete fomation of your tooth, or an absence at the end of the tooth c(called the aapex), an opening may exist between the root canal and the bone or tissue surrounding the tooth. This opening may exist between the root canal and the vone or tissue surrounding bone and tissue. An apicoectomy may be necessary for retrieving the filling material and sealing the root canal. Teeth that receive root canal treatment may be more prone to cracking and breaking over several year's time, which may ultimately require a bridge or partial denture.
11. **PERIODONTAL(TISSUE AND BONE) TREATMENT:** I understand that I have a serious condition, causing gum and bone inflammation or bone loss and that it can lead to the loss of my teeth. The alternative treatment plans have been explained to me, including gum surgery, preplacements and/ or extractions.

I herby request and authorize the Dentist and their staff, to perform dental work upon me for the purpose of attempting to improve my appearance, function and the health of my mouth, teeth, bone and tissues , as explained above.

The effect and nature of the proceeding to be performed, and the risks involved, as well as the possible alternative methods of treatment have been fully explainedto me.

I also authorize the operating Dentist and Assistants to perform any other procedure which they may deem necessary or desirable in attempting to improve the condition stated on the diagnostic treatment form, or treat unhealthy or unforeseen conditions that may be encountered during the operation.

I know that the practice of Dentistry and surgery is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the treatment which i have herein requested and authorized.

Alternatives and possible bad reactions have been explained to me in detail. Complications, such as infection, hemorrhage and/or bleeding, scarring, cantraction, possible deformities, prolonged healing time over the estimate, reaction to any drugs before, during and after surgery, numbness or itching of the tongue, lip, teeth, tissues, (Parasthesia), fractured jaw, Temporamandibular joint (TMJ) Complication, which could cause localized and systemic pain requiring future treatments including joint surgery, etc, have been clearly explained to me.

CONSEQUENCES OF NOT PERFORMING TREATMENT: This course of treatment will help to relieve your symptoms. If no treatment were performed, you would continue to experience symptoms, which could include pain and/or infection, derterioratoin of the bone surrounding your teeth, changes to your bite, discomfort in your jaw joint and possibly the premature loss of these and other teeth.

Every reasonable effort will be made to ensure that your condition is treated properly, although it is not possible to guarantee perfect results. By signing below, you acknowledge that you have received adequate information about the proposed treatment, that you understand this information and that all of your questions have been answered fully.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT AND THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE. ANYTHING I DID NOT UNDERSTAND HAS BEEN EXPLAINED TO ME.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL BINDING ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

Signature:_____ Date: _____
Patient or Legal Representative

Witness:_____ Date: _____

Doctor: _____ Date: _____

This form is double-sided

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PATIENT REGISTRATION

PATIENT INFORMATION

PATIENT'S FIRST NAME	INITIAL	LAST NAME	PREFERS TO BE CALLED	
ADDRESS			BIRTHDATE	AGE
CITY	STATE	ZIP	☐ MALE ☐ FEMALE	☐ MARRIED ☐ SINGLE
HOME PHONE	CELL PHONE	WORK PHONE	SOCIAL SECURITY NUMBER	
EMAIL			DRIVER LICENSE NUMBER	

IF PATIENT IS A MINOR, PLEASE PROVIDE	PARENT/LEGAL GUARDIAN NAME		RELATIONSHIP	
	ADDRESS	CITY	STATE	ZIP
HOME PHONE	CELL PHONE	WORK PHONE	EMAIL	
WITH WHOM DOES THE CHILD RESIDE? ☐ MOTHER ☐ FATHER ☐ BOTH ☐ OTHER _____			SOCIAL SECURTY NUMBER	

PLEASE PROVIDE EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT PERSON	PHONE NUMBER	RELATIONSHIP	
ADDRESS	CITY	STATE	ZIP
NAME OF CLOSEST RELATIVE NOT LIVING WITH YOU	PHONE NUMBER	RELATIONSHIP	
ADDRESS	CITY	STATE	ZIP

THE BIGGEST COMPLIMENT OUR PATIENTS CAN GIVE US IS THE REFERRAL OF THEIR FAMILY AND FRIENDS…

WHOM MAY WE THANK FOR REFERRING YOU?	ARE THEY A PATIENT HERE?

OTHER

☐ BUILDING SIGN ☐ MAILER/ADVERTISEMENT ☐ WEBSITE
☐ INSURANCE COMPANY ☐ YELLOW PAGES ☐ _____

IF YOU HAVE DENTAL INSURANCE, PLEASE PROVIDE

PRIMARY CARRIER		
INSURANCE COMPANY NAME	INSURANCE PHONE	
EMPLOYER NAME	EMPLOYER PHONE	
INSURED NAME		
BIRTH DATE	RELATIONSHIP TO PATIENT	
INSURED INSURANCE I.D. NUMBER	GROUP NUMBER	
INSURED SOCIAL SECURITY		
IF STUDENT, COLLEGE NAME	☐ FULL TIME ☐ PART TIME	

SECONDARY CARRIER		
INSURANCE COMPANY NAME	INSURANCE PHONE	
EMPLOYER NAME	EMPLOYER PHONE	
INSURED NAME		
BIRTH DATE	RELATIONSHIP TO PATIENT	
INSURED INSURANCE I.D. NUMBER	GROUP NUMBER	
INSURED SOCIAL SECURITY		
IF STUDENT, COLLEGE NAME	☐ FULL TIME ☐ PART TIME	

PLEASE TURN OVER AND SIGN

PATIENT REGISTRATION

ACKNOWLEDGEMENT & CONSENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnosc aids deemed appropriate by doctor to make a thorough diagnosis of my, or my dependent's, dental needs.

2. I give consent to the doctor's or designated staff's use and disclosure of any oral, wrien and/or electronic health records that are individually idenfiable as mine, or my dependent's, for the purpose of carrying out my treatment, payment and health care. I understand that only the minimum amount of informaon necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

3. I hereby authorize and direct payment of the dental insurance benefits otherwise payable to me for services rendered, directly to Smiles on Bristol Dentistry. In the event that the insurance company misdirects payment to me, I understand that I am responsible to immediately remit such payments to Smiles on Bristol Dentistry

4. I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that either a 1-1/2% late charge (18%APR) or a $15 late charge per late payment may be added to my account. I further agree to inform Smiles on Bristol Dentistry of any address or phone number change within 30 days of such a change. In the event I fail to do so I authorize Smiles on Bristol Dentistry to use all due means, including the use of credit history records, to ascertain my new address for billing purposes.

PATIENT SIGNATURE_____DATE_____

PARENT/RESPONSIBLE PARTY SIGNATURE_____

RELATIONSHIP TO PATIENT_____

WITNESS_____