Les Samuelson, D.D.S. & Diane White, D.D.S.

255 West Central Avenue, Suite 101
Brea, CA 92821

Please Print Clearly

Date: _____

Patient Information

1 _____
Last Name First Middle

2 _____
Address Apt

3 _____
City State Zip

4 _____
Home Phone Cell Phone

5 _____
Work Phone Social Security Number

6 _____
E-mail Address

7 _____
Birth Date Age

8 _____
Marital Status Spouse's Name

9 _____
Your Employer

10 _____
Employer's Address

11 _____
City State Zip

12 _____
If Patient is a Student, name of School

13 _____
Whom do we thank for referring you

14 _____
Former Dentist

15 _____
Date of Last Visit Date of last X-rays

Responsible Party Information

(Complete only if patient is under 18 years of age.)

1 _____
Last Name First Middle

2 _____
Address Apt.

3 _____
City State Zip

4 _____
Home Phone Work Phone

5 _____
Social Security Number

6 _____
Driver's License Number (if applicable) State

7 _____
Birth Date Age

8 _____
School Attending Grade

9 _____
Employer (if any)

10 _____
Employer's Address

11 _____
City State Zip

12 _____
Relationship to patient

Cell phone consent: I consent to the dental practice using my cell phone number to (check one or both) ◯ call &/or ◯ text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time. My cellphone number is listed above.

Patient initials: _____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the tendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. It is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance.

I understand that if my insurance company fails to pay a claim within 30 days of billing, the full amount of the claim becomes my responsibility to pay within the next 30 days. Interest charges will be applied to claims not paid promptly. **PLEASE NOTE:** We cannot accept responsibility for collecting your insurance claim or negotiating settlement on a disputed claim.

The patient's portion of the treatment charges are due and payable on the day of treatment, unless other written arrangements have been made in advance.

_____

PATIENT'S SIGNATURE / RESPONSIBLE PARTY'S SIGNATURE

INSURANCE INFORMATION

Primary Carrier

Employee Name: _____ Social Security #: _____
Mailing Address: _____ Phone #: _____
City, Sate. Zip: _____ Date of Birth: _____

Employer (Company) Name: _____
Mailing Address: _____ Phone: _____
City, State. Zip: _____

Insurance Company Name: _____
Mailing Address: _____ Phone: _____
City, State, Zip: _____

Group or Policy #: _____ Group or Union Name: _____
Union Local: _____
Patient Relationship to Employee: (Circle one) SAME SPOUSE CHILD

Secondary Carrier (if any)

Employee Name: _____ Social Security #: _____
Mailing Address: _____ Phone #: _____
City, Sate, Zip: _____

Employer (Company) Name: _____
Mailing Address: _____ Phone: _____
City. State. Zip: _____

Insurance Company Name: _____
Mailing Address: _____ Phone: _____
City. State. Zip: _____

Group or Policy #: _____ Group or Union Name: _____
Union Local: _____
Patient Relationship to Employee: (Circle one) SAME SPOUSE CHILD

The undersigned patient/responsible party, in requesting examination &/ or treatment, authorizes the release of all information (including x-rays) relating to that examination or treatment to health service plans & insurance companies. I, the undersigned patient/responsible party, herby authorize payment directly to the dentist of the group insurance benefits otherwise payable to me, but not to exceed the actual charges for the covered services. I, the undersigned patient/responsible party, understand that I am financially responsible for any charges not covered by the group insurance benefits.

_____

Patient Signature / Responsible Party Signature Date

TIME 10:43 AM DATE 7/12/2011

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

MEDICAL DENTAL HEALTH HISTORY

(Cont.)

Women Only Complete Questions 22-25

22. Are you pregnant? Please circle: Yes No If so, how many months? _____
23. Date of last Menstrual Cycle _____
24. I understand that I must report to my dentist if I have missed my menstrual cycle or am late.

Taking x-rays and routine dental work during the first trimester (first three months) could be harmful to the fetus.

SIGNATURE: _____ **DATE:** _____

25. Are you currently taking birth control pills? Please circle: Yes No

Taking antibiotics orally or by injection while on the birth control pill could inactivate the pill allowing you to become pregnant.

26. Is there anything of importance in your medical or dental history that has not been asked? If so, please explain:

_____

Closing Statement

I understand that the information that I have provided on this form is essential to determining my dental health needs and the provision of dental treatment. I understand that if changes occur in my health or if my medicines change, I will inform the Doctor at the next appointment without fail. I have read, and undersigned each question, and have answered all of them truthfully and to the best of my ability.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN: _____

DATE: _____

DOCTOR'S SIGNATURE: _____ **DATE:** _____

Consent for Dental Treatment

I hereby consent to the treatment deemed necessary by the doctor, including the use of anesthetics, sedatives and/or radiographs.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN: _____

DATE: _____

Cosmetic Questionnaire

With recent advancements in materials and techniques, many of our patients are inquiring about cosmetic dental procedures. In order to better serve you, please take a moment to let us know how you feel about the appearance of your smile.

	Yes	No
Do you like the appearance of your teeth?	☐	☐
Are your teeth as straight as you would like them to be?	☐	☐
Are you happy with the length, width, and shape of your teeth?	☐	☐
Do you have any chipped teeth?	☐	☐
Do you have any missing teeth?	☐	☐
Do you have any spaces between your teeth?	☐	☐
Do you have any discoloration, stains, or spots on your teeth?	☐	☐
Would you like your teeth to be whiter?	☐	☐
Do you have any dental work that you do not like?	☐	☐
Do you have any silver fillings that you would like changed to white?	☐	☐

From the above questions, which concerns you the most?

_____

If you could change anything about the appearance of your teeth what would it be?

_____ _____

Les Samuelson D.D.S. & Diane White D.D.S.

Financial

Thank you for selecting us as your dental care provider. We are committed to the highest level of quality, preventive treatment. Please understand that payment for services rendered is part of your treatment. Outlined below is our financial policy. Please read it carefully and sign it before being seen by the doctor.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE

WE ACCEPT CASH, CHECKS, or VISA/MASTERCARD

IF YOU HAVE DENTAL INSURANCE, YOU ARE EXPECTED TO PAY YOUR ESTIMATED PORTION, ALL CO-PAYS, OR DEDUCTIBLES AT THE TIME OF SERVICE.

WE OFFER FINANCING THROUGH OUTSIDE FINANCIAL INSTITUTIONS WITH PRIOR APPROVAL

Our practice is committed to providing the best treatment for our patients, based on a diagnosis of what is needed to save and prevent further loss or damage to your gums or teeth. We charge fees that are usual and customary for our area. Our diagnosis will not be based on what your insurance company will cover, the amount of money you have left on your deductible, or how economical the treatment will be. Again, it will be based on what is in the best interest of your dental and health care. Regardless of any insurance company's arbitrary determination of what usual and customary is, you are responsible for payment.

Regarding Insurance

We may accept assignment of insurance benefits after your first appointment. However, we do require all co-pays be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless we have your current insurance information. Your insurance policy is a contract between you and your insurance company. We are not a part to that contract. If your insurance company has not paid your account within 30 days you are required to pay the balance in full. We are not responsible for unpaid claims; please contact your insurance company or human resources department. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered necessary under your insurance plan.

A 1.5% finance charge (18% annually) will be added to any balance that is more than 60 days overdue. To prevent finance or rebilling charges, we ask that you comply with your original financial arrangement. This will eliminate all of the extra time for processing, the embarrassment and the awkwardness of collecting on services rendered. If your account becomes delinquent for more than 60 days and you are in need of additional treatment, full payment must be made prior to the time of service.

Appointments

Please help us serve you better by keeping scheduled appointments. This time has been reserved especially for you. **Unless cancelled at least 48 hours in advance, our policy is to charge for missed appointments. The charge will be determined by the doctors based on the amount of time scheduled for your appointment.**

Thank you for your understanding. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to the Financial Policy:

Patient or Responsible Party _____ Date_____

Patient Acknowledgment of receipt of Dental Materials Fact Sheet

I, _____, acknowledge that I have received from _____
Patient's Name Dental Office Name
a copy of the Dental Materials Fact Sheet dated October 2001.

_____ _____
Patient Signature Date

The following document is the Dental Board of California's Dental Materials Fact Sheet. *The Department of Consumer Affairs has no position with respect to the language of this Dental Material Fact Sheet; and it's linkage to the DCA web site does not constitute and endorsement of the content of this document.*

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The Dental Board of California
Dental Materials Fact Sheet
Adopted by the Board on October 17, 2001

As required by Chapter 801, Statutes of 1992, the Dental Board of California has prepared this fact sheet to summarize information on the most frequently used restorative dental materials. Information on this fact sheet is intended to encourage discussion between the patient and dentist regarding the selection of dental materials best suited for the patient's dental needs. It is not intended to be a complete guide to dental materials science.

The most frequently used materials in restorative dentistry are amalgam, composite resin, glass ionomer cement, resin-ionomer cement, porcelain (ceram c), porcelain (fused-to-metal), gold alloys (noble) and nickel or cobalt-chrome (base-metal) alloys. Each material has its own advantages and disadvantages, benefits and risks. These and other relevant factors are compared in the attached matrix titled "Comparisons of Restorative Dental Materials." "A Glossary of Terms" is also attached to assist the reader in understanding the terms used.

The Statements made are supported by relevant, credible dental research published mainly between 1993-2001. In some cases, where contemporary research is sparse, we have indicated our best perceptions based upon information that predated 1993.

The reader should be aware that the outcome of dental treatment or durability of a restoration is not solely a function of the material from which the restoration was made.

The durability of any restoration is influenced by the dentist's technique when placing the restoration of the ancillary materials used in the procedure, and the patient's cooperation during the procedure. Following restoration of the teeth, the longevity of the restoration will be strongly influenced by the patient's compliance with dental hygiene and home care, their diet and chewing habit.

Dr. Les Samuelson, D.D.S.
Dr. Diane White, D.D.S.

ACKNOWLEDGMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

I have read the Privacy Notice and understand my rights contained in this notice.

By way of my signature, I provide Dr. Les Samuelson and Dr. Diane White with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment and healthcare operations as described in the Privacy Notice.

_____
Patient's Name (print)

_____ _____
Patient's Signature Date

_____ _____
Authorized Facility Signature Date

For Office Use Only

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

Individual refused to sign
Communications barriers prohibited obtaining acknowledgment
Other (Please Specify)

_____
_____
_____