# La Mesa Dental

## Patient Information (Please Print)

Date _____

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Name _____ (First / MI / Last) Social Security # _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Home phone # _____ Cell phone # _____

E-mail # _____ Drivers License # _____

You or your parent's employer _____ Occupation _____

Whom may we thank for referring you to us? _____

May we phone, email, or send a text to confirm your appointments? ❒ Yes ❒ No

May we leave a message on your answering machine at home or on your cell phone? ❒ Yes ❒ No

May we discuss your medical condition with any member of your family? ❒ Yes ❒ No

If yes, please list name and relation to you: _____

## Responsible Party (if different from above)

Person responsible for this account? _____ Date of Birth _____ Drivers Lic # _____

Relationship to patient _____ Social Security # _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Name of employer _____ Work phone # _____

## Dental Insurance Information

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____

Name of employer _____ Work phone # _____

Insurance Co. _____ Group # _____ ID # _____

Insurance Co Phone # _____

Do You Have Additional Insurance? ❒ No ❒ Yes If Yes, Please Complete The Following:

Name of insured _____ Relationship to patient _____ Birthdate _____

Social Security # _____ Name of employer _____ Work phone # _____

Insurance Co. _____ Group # _____ ID # _____

Insurance Co Phone # _____

## Terms & Conditions

As a condition of treatment by this office. I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

**Assignment of Insurance:** I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy.

A service charge of 1½% per month(18% per annum)(but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

In consideration of the professional services rendered to me by the Doctor and/or his staff, I agree to pay, the reasonable value of said services to said doctor or his assignee, at the time said services are rendered or within (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me in writing within the time for payment thereof. Additionally I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's and/or collection fees.

If my account is sent to a collection agency a $50 charge will be applied to my account.

I have read the above conditions of treatment and agree to their content:

**A 24 Hour Cancellation Notice is required, to avoid a charge.**

Signed: _____ Date: _____

# Medical History

Medical Doctor: _____ Phone # _____ Date of last visit _____

Pharmacy Name: _____ Phone: _____

Address: _____

Please list all major surgeries and date:

Please list all medications you are currently taking: _____

Allergies: _____

Have you used Bisphosphonate drugs used to treat Osteoporosis or bone cancer related issues? _____

Have you taken - Redux, Phen/Phen, Aspirin or Coumadin? ❒ Yes ❒ No Last date taken _____

(Women) Are you pregnant? ❒ Yes ❒ No Nursing? ❒ Yes ❒ No Taking birth control pills? ❒ Yes ❒ No

**Have or have ever had any of the following? Please check (✓) the appropriate box**

| Yes | No | | Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ❒ | ❒ | Anemia | ❒ | ❒ | Cortisone Treatments | ❒ | ❒ | Heart Murmur | ❒ | ❒ | Respiratory Disease |
| ❒ | ❒ | Arthritis, Rheumatism | ❒ | ❒ | Cough, Persistent | ❒ | ❒ | Hemophilia | ❒ | ❒ | Rheumatic Fever |
| ❒ | ❒ | Artificial Heart Valves | ❒ | ❒ | Cough up blood | ❒ | ❒ | Hepatitis-Type A, B, C | ❒ | ❒ | Scarlet Fever |
| ❒ | ❒ | Artificial Joints | ❒ | ❒ | Diabetes | ❒ | ❒ | Herbal Supplements | ❒ | ❒ | Shortness of Breath |
| | | Date _____ | ❒ | ❒ | Eating Disorder/Bulimia | ❒ | ❒ | High Blood Pressure | ❒ | ❒ | Skin Rash |
| ❒ | ❒ | Asthma | ❒ | ❒ | Epilepsy | ❒ | ❒ | HIV Positive | ❒ | ❒ | Sleep Apnea |
| ❒ | ❒ | Blood Disease | ❒ | ❒ | Fainting | ❒ | ❒ | Jaw Pain | ❒ | ❒ | Stroke _____ |
| ❒ | ❒ | Cancer | ❒ | ❒ | GERD/Acid Reflux | ❒ | ❒ | Kidney Disease | ❒ | ❒ | Thyroid Problems |
| ❒ | ❒ | Chemical Dependency | ❒ | ❒ | Glaucoma | ❒ | ❒ | Liver Disease | ❒ | ❒ | Tobacco Habit |
| ❒ | ❒ | Chemotherapy | ❒ | ❒ | Headaches | ❒ | ❒ | Nervous Problems | ❒ | ❒ | Vaping |
| ❒ | ❒ | Circulatory Problems | ❒ | ❒ | Heart Problems | ❒ | ❒ | Pacemaker | ❒ | ❒ | Tonsillitis |
| | | | | | Describe _____ | ❒ | ❒ | Psychiatric Care | ❒ | ❒ | Tuberculosis |
| | | | | | | ❒ | ❒ | Radiation Treatment | ❒ | ❒ | Ulcer |
| | | | | | | | | | ❒ | ❒ | Venereal Disease/STD |

# Authorization

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I authorize La Mesa Dental Group, dentist(s), and/or dental auxiliary personnel in charge of my care to administer any treatment, anesthetics, and dental procedures necessary in the diagnoses and treatment of my case.

Person to contact in case of emergency _____ Phone # _____

Date _____ Signature of Patient, Parent or Guardian _____ Signature of Examining Dentist _____

| Update | Initial | |
|---|---|---|
| | | |
| | | |
| | | |

La Mesa Dental

7872 La Mesa Boulevard
La Mesa, CA 91942
(619) 464-1211

# PATIENT CONSENT TO TREATMENT

For your convenience, we have made this generalized dental consent for your review and signature.

**1. DRUGS, MEDICATIONS AND LOCAL ANESTHETICS**

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 (severe allergic reaction).

**2. CHANGES IN TREATMENT PLAN**

I understand that during treatment it may be necessary to change and/or add procedures because of conditions found while working on the teeth that were not discovered during examination the most common being root canal therapy following routine restorative procedures.

**3. REMOVAL OF TEETH**

If the teeth are savable/restorable the alternatives to removal of teeth are root canal therapy, crowns, and periodontal surgery, etc. 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 in my teeth, lips, tongue and surrounding tissue (Paresthesia) 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, the cost of which is my responsibility.

**4. CROWNS (CAPS) AND BRIDGES**

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 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. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation.

**5. DENTURES, COMPLETE OR PARTIAL**

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances include looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

**6. ENDODONTIC TREATMENT (ROOT CANAL)**

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

**7. PERIODONTAL LOSS (TISSUE & BONE)**

I understand that serious gum problems can lead to bone infection or bone loss that can lead to the loss of my teeth. Alternative treatments include gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

**I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for myself or my minor child. I have had full opportunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my satisfaction.**

Signature of Patient _____ Date _____

Signature of Parent, Guardian or Personal Representative _____ Date _____

Relationship to Patient _____

# Dental Billing Preference Form

**Guarantor Information:**

Name: _____ Date of Birth: _____

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## Billing Preference Selection

Please select your preferred method to receive billing statements from our dental office:

**You may choose more than one**

- [ ] **Mail**
  Mailing Address:
  Street: _____
  City: _____ State: _____ Zip Code: _____
- [ ] **Email**
  Email Address: _____
- [ ] **Text Message**
  Mobile Number for Billing Texts: _____

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**Authorization:**

By selecting a billing preference above, I authorize La Mesa Dental to send my billing statements and related communications through my selected method. I understand that I can change this preference at any time by contacting the office.

Signature: _____ Date: _____

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**For Office Use Only:**

Date Received:_____Staff Initials: _____ Preference Entered in System: [ ] Yes

Chart #: _____

# La Mesa Dental

7872 La Mesa Blvd. • La Mesa, CA 91941
Phone (619) 464-1211 • Fax (619) 464-3211

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

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

_____
Please Print Name

_____
Signature

_____
Date

**Patient Acknowledgment of Receipt of Dental Materials Fact Sheet, I _____ acknowledge I have reviewed a copy of the Dental Materials Fact Sheet updated 2004 from LA MESA DENTAL GROUP**

_____ _____
**Patient 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 refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____