Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # _____
SS#/SIN _____
Date _____
Patient's Sex ☐ F ☐ M

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Home Phone _____
Address _____ City _____ State/Prov. _____ Zip/P.C. _____
Email _____ Cell Phone _____
Do you prefer to receive calls at your: ☐ Home ☐ Work ☐ Cell Phone
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
If Student, Name of School/College _____ City _____ State/Prov. _____ ☐ Full Time ☐ Part Time
Patient or Parent/Guardian's Employer _____ Work Phone _____
Business Address _____ City _____ State/Prov. _____ Zip/P.C. _____
Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____
Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Email _____ Cell Phone _____
Driver's License # _____ Birthdate _____ Financial Institution _____
Employer _____ Work Phone _____ SS#/SIN _____
Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance Company _____ Group # _____ Policy/ID # _____
Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance Company _____ Group # _____ Policy/ID # _____
Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Over Please

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain _____		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax (alendronate), Boniva (ibandronate), Actonel (risedronate) or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revatio (sildenafil), Cialis (tadalafil) or Levitra (vardenafil) in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐

9. Do you have or have you had any of the following?	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other _____	☐	☐

	Yes	No
10. Are you wearing contact lenses?	☐	☐
11. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____	☐	☐
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
13. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

Payment is due in full at the time of treatment unless prior arrangements have been approved.
This office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.
I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

X _____

Signature of patient (or parent/guardian if minor) Date

Dr. Hattar Dental

9950 Foothill Blvd., Suite T
Rancho Cucamonga, CA 91730
(909) 980-4816

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among multiple health care providers who may be involved in that treatment directly and indirectly. Obtain
- payment from third party.
  Conduct normal health care operations such as quality assessments and
- physicians certifications.

I have received, read and understand your NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT from time to time and that I may contact this organization at anytime at the address above to obtain a current copy of the NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT.

Patient Name: _____

Relationship to Patient: _____

Signature: _____
(Parent or guardian if the patient is a child)

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature upon receiving the NOTICE OF PRIV ACY PRACTICES ACKNOWLEDGEMENT, but was unable to do so as patient was unwilling.

Initials _____ date _____

Dr. Hattar Dental
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(909) 980-4816

Consent for Treatment:

In reading and signing this form it is understood that English is the language that I understand and use to communicate

Initials _____

1. Drugs, Medications, and Anesthesia:

I understand that antibiotics, analgesics, and other medications may cause adverse reactions, some of which, but are not limited to, redness, swelling of tissue, pain, itching, vomiting, dizziness, miscarriage and cardiac arrest. I understand that medications and anesthetics may cause drowsiness and lack of coordination, which can be increased by the use of alcohol or other drugs. I have been advised not to consume alcohol, nor operate any vehicle or hazardous devise until I have fully recovered from their side effects. I understand that occasionally upon injection of local anesthetic I may have prolonged, persistent anesthesia, numbing and/or irritation to the area of injection. I also understand that if I choose to utilize nitrous oxide, atarax, chloryl, hydrate, zanax or any other sedative possible risks include, but are not limited to, loss of consciousness, obstruction of airway, anaphylactic shock and/or cardiac arrest. I understand that someone needs to drive me home from the dental office after I have received sedation. I also understand that someone needs to watch me closely for a period of 8 to 10 hours, following my dental appointment, to observe for possible delirious side effects, such as obstruction of airways.

Initials _____

2. **Hygiene and Periodontics (tissue and bone loss):**

I understand that the long term success of treatment and status of my oral condition depends on my efforts at proper oral hygiene (i.e. brushing and flossing) and maintaining regular recall visits.

Periodontics- I understand that I have a serious condition causing gum inflammation and bone loss, which can lead to loss of my teeth and other complications. The various treatment plans have been explained to me including gum/bone surgery and/or extractions. I also understand that although these treatments have a high degree of success, they **cannot** be guaranteed. Occasionally, treated teeth may require extractions.

Initials _____

3. **Removal of Teeth:**

I understand that the purpose of the procedure/surgery is to treat and possibly correct my diseased oral tissue. The doctor has advised me that if this condition persists without treatment or surgery, my present oral condition could worsen in time. Potential risks include, but are not limited to the following:

A. Post operative discomfort, swelling, prolonged bleeding, tooth sensitivity to hot or cold, gum shrinkage (possibly exposing crown margins) tooth loosening, delayed healing (dry socket) and/or infection (requiring a prescription or additional treatment).
B. Injury of adjacent teeth, caps or fillings.
C. Limitation of opening mouth, stiffness of facial and/or neck muscles, change in bite, or temperomandibular joint difficulty.
D. Residual root fragments or bone spicules left when complete removal would require extensive surgery or needless surgical complications.
E. Possible bone fractures which may require wiring or surgical treatment.
F. Opening of the sinus (a normal cavity situated above the upper teeth requiring additional surgery).
G. Injury to the nerve underlying the teeth resulting in itching, numbness, or burning of the lip, chin or gums. This may persist for several weeks, months, or in rare instances, permanently.

Initials _____

4. **Fillings:**

I have been advised of needing a filling, either amalgam (silver) or composite (plastic), to replace tooth structure lost to decay. I understand that with time fillings will need to be replaced due to wearing of material. In cases where very little tooth structure remains, or existing tooth structure fractures off, I may need to receive more extensive treatment (such as a root canal, post and build up, and crowns), which would require a separate charge. I also understand that the amalgam (silver) restoration is an acceptable procedure according to the America Dental Association guidelines and, as such, is a treatment used by *Dr. Hattar Dental*, the advantages and disadvantages of alternate material have been explained to me.

Initials _____

5. **Endodontic Treatment (Root Canal and Pulpotomy)**

The purpose and method of root canal therapy have been explained to me, as well as, reasonable alternative treatments, and the consequences of non-treatment. I understand that following a root canal, my tooth will be brittle and must be protected against the possibility of fracturing, therefore, placement of a crown is recommended. I understand that treatment risks can include, but are not limited to the following.

A. Post treatment discomfort lasting a few hours to several days for which medication will be prescribed, if deemed necessary by the doctor.
B. Post treatment swelling ofthe gum area in the vicinity of the treated tooth or facial swelling, either of which may persist for several days or longer.
C. Infection.
D. Restricted jaw opening.
E. Breakage of root canal instruments during treatment, which may in the judgement of the doctor be left in the treated root canal or bone as part of filling material, or it may require surgery for removal.
F. Perforation of the root canal with instruments, which may require additional surgical treatment or result in premature tooth loss or extraction.
G. Risk of temporary or permanent numbness in treated area.

If an "open and med" or pulpotomy procedure is performed, I understand that this is not a permanent treatment, I need to pay for and finish the final root canal therapy. If the root canal treatment is not finalized I expose myself to infection and/or possible extraction of tooth.

Initial_____

6. **Crowns and Bridges (caps)**

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I understand that at times, during the preparation of a tooth for a crown, pulp exposure may occur, resulting in possible root canal therapy. I understand that like natural teeth, crowns and bridges need to be kept clean, with proper oral hygiene and periodic cleanings, otherwise decay may develop underneath and/or around the margins of the restoration, leading to further dental treatment.

7. **Dentures: Complete or Partial**

The possible complications of wearing dentures has been explained to me including looseness, soreness, possible breakage and relining the causes the to tissue change. Follow up appointments are an integral part of maintenance and success of a prosthetic appliance. Persistent sore spots should be immediately examined by the doctor. I further understand that surgical intervention may be needed for dentures to be properly fitted. I also understand that due to bone loss or other complicating factors, my dentures may not be to my satisfaction.

Initial_____

I understand that no guarantee or assurance has been given that the proposed treatment will be curative and/or successful to my complete satisfaction. I agree to cooperate completely with the recommendations of the doctor. While I am under his/her care, realizing that any lack of same could result in less than optimum results.

I certify that I have had an opportunity to read and fully understand the terms and words within the above, including the opposing side of this document, and consent to the operation/treatment and explanation referred to or made. I have been encouraged to ask questions, and have had them answered to my satisfaction.

_____ Date _____

Full Signature of Responsible Party

Dr. Hattar Dental

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(909) 980-4816

Financial Arrangements:
We are committed to providing you with the best possible care. If you have dental insurance, we are devoted to helping you receive your maximum allowable benefits. In order to achieve these goals, your cooperation and understanding of our payment policy is needed. *Payment is due at the time of services rendered,* unless prior payment arrangements have been made and authorized by our office manager. Acceptable forms of payments are Cash, Visa, MasterCard, Discover, American Express, Care Credit and Debit Cards. As a courtesy to our patients all treatment rendered will be processed and billed directly to your insurance provider by Dr. Hattar Dental. Balances over 30 days *may* be subject to additional fees including an interest charge of 1.50% or a minimum of $2.00 per month, whichever is greater. *There is a $25.00 fee for each returned check.*

We will gladly discuss your treatment plan and answer any questions relating to your insurance benefits. However, you must realize that:

- Your benefits are a contract between you and your insurance company.
- Our fees generally fall within the acceptable range of most insurance's, however, in the event that your insurance company's allowed fees are below our UCR fees, *the portion that your insurance does NOT cover, must be payable by the patient.*
- Not all services are a covered benefit within your insurance providers. Insurance providers have certain services they will not cover. These charges must be paid by the patient before services are rendered.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are *your* responsibility for the services rendered. I understand that I am responsible for all charges not covered by my insurance company, including but not limited to, attorney fees and collection fees which may be incurred to satisfy this obligation. We realize that problems due occur from time to time, thus affecting a timely payment on your account, however, if such problems do arise, we encourage you to contact us promptly.

Guarantee:
I understand that not all dentistry is precise, therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee has been made in regards to the treatment plan I have authorized. I understand that a pre-determination of benefits is not a guarantee of benefits and/or payment. It is subject to change based on the following: accepted benefits, eligibility, and availability.

I agree that a photocopy of this authorization shall be valid and effective as the original is forever. I am of legal age and capable of signing for myself and/or for my dependents. I will inform the doctor and/or dental staff of any changes with the following: medical history, insurance information, and patient information. I acknowledge that I have read and fully understand the terms above.

I understand the office of "Dr. Hattar Dental" request to have information released for the purpose of placing on dental claims. I am responsible for any information relating to my health care claims. I authorized this office to affix my name and signature to any and all claims related to me. This "Signature on File" will be valid from this date and shall not expire, unless written termination is given to me. A photocopy of this document may act as an original. This "Signature on File" is both for personal claims with "Dr. Hattar Dental" and the insurance company that I belong to as a beneficiary.

X_____ X_____

Print name of patient or parent/legal guardian to pt

Full signature of patient or parent/legal guardian to pt