We are delighted to welcome you to our practice and are honored that you chose us to serve your dental needs. Our goal is to help you look and feel your very best through excellence in dental care.

Our office is unique from other dental offices that you may have been to in the past. We are a **SPECIALTY** practice and have a full time general dentist as well. Our team of highly trained specialists includes:

- Cosmetic Dentistry
- Periodontist
- Oral Surgeon
- Implant surgeon
- Endodontist
- Orthodontists/Invisalign
- Full-time hygienist
- Pediatric Dentist

The mission of **Orange County Dental Specialists** is to provide each patient with all their necessary treatment in one location. **This saves you time, money and allows OCDS to monitor your treatment and provide you the best care possible.**

If you are ever unable to make the appointment you have scheduled with us, please notify us as soon as possible, so we may offer that time to other patients who are waiting to be seen. We require 48 hours notice for any cancellation.

We look forward to meeting you and your family!

Please visit our website for additional information www.ocdentalspecialists.com

15825 Laguna Canyon Road Suite 206 Irvine, CA 92618

Date: _____ Whom may we thank for referring you? _____

PERSONAL INFORMATION: ☐ Mrs. ☐ Ms. ☐Miss ☐Mr.

Last Name: _____ First Name: _____ M.I _____

Address: _____ City: _____State: _____ Zip: _____

Home Phone: (_____) _____ Work: (_____) _____ Cell: (_____) _____

Email:_____ ☐ I would like to receive reminders via email.

Social Security Number: _____ **Date of Birth**: _____

Male ☐ Female ☐ Marital Status: Single ☐ Married ☐ Divorced ☐ Widow ☐

Employer: _____ Position: _____

Emergency Contact: _____Phone Number: _____ Relationship: _____

DENTAL INSURANCE INFORMATION:

Dental Insurance Company: _____ ID Number: _____

Group Number: _____ Plan type: ☐PPO ☐ HMO Phone Number: _____

Insured's Name: __SSN: _____ Date of Birth: _____

MEDICAL/DENTAL HISTORY

Are you required to take antibiotics before any dental treatment ☐ Yes ☐ No

When was your last complete dental check-up and cleaning: _____?

Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth) ☐ Yes ☐ No

Name, Address, Phone Number of your medical physician:

_____

Do you snore? **YES NO** Do you find it difficult to stay awake during the day? **YES NO**

Do you lack energy in the morning? **YES NO** Do you awaken from sleep gasping for air? **YES NO**

Are you required to take antibiotics before any dental treatment due to a heart murmur or mitral valve prolapse? YES or NO **Do you wear a Night Guard?** YES or NO

Are you allergic to Latex? YES or NO **(TMJ)** or **joint problems** YES or NO

Mouth/Teeth: Do you have or have you had:

Bleeding, sore gums YES or NO **Loose teeth** YES or NO

Clenching/grinding YES or NO **Clicking or popping jaws** YES or NO

Medications:

Are you taking any of the following (Please provide us a list of medications you are currently taking)

- ☐ Antibiotics, sulfa drugs
- ☐ Anticoagulants; (blood thinners, Coumadin, Aspirin, etc)
- ☐ Medicine for high blood pressure
- ☐ Steroids
- ☐ Antihistamines, Aspirin
- ☐ Medication to treat diabetes
- ☐ Phen-Fen: _____ How long ago was your last heart exam: _____

Please list all the medications you are currently taking. Include the dosage, how often, and the reason.

_____

Allergies:_____

_____

I. Circle Appropriate Answer (leave blank if you do not understand the question):

Yes	No	Have you been hospitalized or had a serious illness in the last three years?			
Yes	No	Have you had problems with your prior dental treatment?			
Yes	No	Are you in pain now? Please explain_____			
Yes	No	Dizziness?	Yes	No	Headaches?
Yes	No	Recent weight loss, fever, night sweats?	Yes	No	Fainting spells?
Yes	No	Persistent cough, coughing up blood?	Yes	No	Blurred vision?
Yes	No	Bleeding Problems, bruising easily?	Yes	No	Seizures?
Yes	No	Sinus Problems?	Yes	No	Excessive thirst?
Yes	No	Difficulty Swallowing?	Yes	No	Frequent urination?
Yes	No	Frequent vomiting, nausea?	Yes	No	Dry Mouth?
Yes	No	Heart Disease?	Yes	No	AIDS?
Yes	No	Heart attack, heart defects?	Yes	No	Tumors, cancer?
Yes	No	Heart murmurs?	Yes	No	Arthritis, rheumatism?
Yes	No	Stroke, hardening of arteries?	Yes	No	Skin disease?
Yes	No	High blood pressure?	Yes	No	Anemia?
Yes	No	Hepatitis, other liver disease?	Yes	No	Herpes?
Yes	No	Stomach problems?	Yes	No	Kidney/bladder disease?
Yes	No	Allergies to: Drugs, foods, medication, latex?	Yes	No	Thyroid or adrenal disease?
Yes	No	Family history of: diabetes, heart problems, tumors?	Yes	No	Diabetes?
Yes	No	Psychiatric care?	Yes	No	Hospitalization
Yes	No	Radiation treatment?	Yes	No	Blood transfusions?
Yes	No	Chemotherapy?	Yes	No	Surgeries?
Yes	No	Prosthetic heart valve?	Yes	No	Asthma, TB, emphysema?
Yes	No	Artificial joint?	Yes	No	Tobacco in any form?
Yes	No	Recreational Drugs?	Yes	No	Alcohol?
Yes	No	Are you or could you be pregnant or nursing?	Yes	No	Taking birth control pills?

The information above is current and accurate. I have listed all medications I am currently taking and listed all products that I am allergic to. I understand that it is my responsibility to notify the office of any changes in intake or allergies.

Patient Signature: _____ Date: _____

Appointment Policy A fee of $50 per scheduled hour is charged for patients who miss or cancel an appointment without 48-hour notice. We charge $25 for returned checks. If you have any questions, please do not hesitate to ask. We are here to help you.

Assignment of Benefits

Our practice will accept an assignment of benefits from your insurance company with the conditions listed below. It is important to understand that the agreement regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for all treatment and services we provide to you, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort save you time and to facilitate payment to our practice from your insurance company. By having our practice process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- We require you to sign this agreement and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our practice.
- We require you to pay the **estimated** copayment, which is the amount not covered by your insurance company, at the time we provide service to you. The copayment is only an **estimate** of charges and may be found to be insufficient after review by your insurance company.
- Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our practice within 60 days, we will ask you to pay the entire balance at that time. You will be responsible for seeking reimbursement from your insurance company at that time.
- Our practice does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- Our practice will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company to our practice.
- **ATTENTION DELTA DENTAL PATIENTS: in certain cases Delta Dental may be mailing the insurance payment to your house. You will be required to forward that money to our office within 7-10 days. You can either endorse the check to OC Dental Specialists or deposit into your bank and pay us directly.**

Financial Policy

We offer several payment options. You can choose from: Cash, Check, MasterCard, VISA, AMEX or Discover Card. We offer a 7% courtesy discount to patients who pay for their treatment in full (only valid on treatment exceeding $4,000).
PLEASE NOTE: We require a 20% deposit to hold all surgery appointments and appointments for longer than 1 hour. You will be asked to pay the deposit at the time you schedule the appointment.
- Convenient Monthly Payment Plans[1] from CareCredit: No interest financing or Long-term low interest financing: Allows you to pay over time. No pre-payment penalties.

Patient Signature (Parent or Guardian) **Patient Name (Please Print)** **Date**

[1]Subject to credit approval