Welcome to Bristol Dental & Orthodontics
2835 S. Bristol St. Suite A
Santa Ana, CA 92704

Today's Date:_____

Patient Information

Name:_____Phone:_____Cell:_____
Last First

Address: _____Apt:_____City:_____Zip:_____

How long in this address:_____Email:_____

Social Security #:_____DL #:_____ Date of Birth:_____ Sex: ☐ M ☐ F

Are you a student: Y N Guardian Name: _____ Gard SSI #:_____

How did you hear about us? _____

Is there anything we can do to make your visit more comfortable? _____

Insurance Information (Primary)

Insurance Company:_____ Employer:_____

Insurance Address:_____ Phone #: _____

Group Name:_____ Group Number:_____

Subscriber/Member ID: _____ Relationship: ☐ Self ☐ Spouse ☐ Child

Insurance Information (Secondary)

Insurance Company:_____ Employer:_____

Insurance Address:_____ Phone #: _____

Group Name:_____ Group Number:_____

Subscriber/Member ID: _____ Relationship: ☐ Self ☐ Spouse ☐ Child

Employer Information

Occupation:_____Employer:_____ Work Phone_____

Financial Agreement

- For my convenience, I hereby authorize payment directly to the dentist of the group insurance benefits otherwise payable to me this office may release my information to my insurance.
- Every effort will be made to help me with my insurance. I understand that I am financially responsible for any charges not covered or denied by my insurance.
- I understand that treatment plans may change and I am responsible for all work actually completed.
- I certify that all information provided is accurate, true, and to the best of my knowledge.

_____ _____

Signature of responsible party or patient
(Parent if patient is a minor)

Date

Dental History

Please check any of the following problems that apply to you:

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Dry mouth
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, ear aches, neck pain
- ☐ Mouth ulcers or cold sores
- ☐ Jaw joint pain (popping)
- ☐ Broken tooth or fillings
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifted teeth
- ☐ Bad breath or bad taste in your mouth

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

- ☐ Dentures
- ☐ Partial dentures
- ☐ Braces
- ☐ Gum treatments
- ☐ Required to take antibiotics prior to dental treatment?

Please share the following dates:

Your last cleaning _____/_____

Your last oral cancer screening _____/_____

Your last complete set of dental x-rays _____/_____

If you could change your smile, you would:

- ☐ Make my teeth whiter
- ☐ Make my teeth straighter
- ☐ Close spaces
- ☐ Replace metal fillings with tooth colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

Name of Previous Dentist:

_____

City: _____ State: _____

Phone number: _____

What is the most important thing to you about your future smile and dental health?_____

_____

_____

On a scale of 1 -10, with 10 being the highest rating:

a) How important is your dental health to you? _____

b) Where would you rate your current dental health?___

c) Dental anxiety or fear? _____

Medical History (Check Y or N to all)

Y N
- ☐ ☐ Anemia
- ☐ ☐ Blood Disease
- ☐ ☐ Excessive Bleeding (INR > 3)
- ☐ ☐ Heart problems or surgery

_____

- ☐ ☐ History of infective endocarditis
- ☐ ☐ Artificial heart valve, repaired heart defect
- ☐ ☐ Pacemaker or implantable defibrillator
- ☐ ☐ Stroke (taking blood thinners)
- ☐ ☐ Rheumatic or scarlet fever
- ☐ ☐ High or Low blood pressure
- ☐ ☐ High Cholesterol
- ☐ ☐ Allergies (Seasonal)
- ☐ ☐ Asthma
- ☐ ☐ Emphysema, Shortness of breath
- ☐ ☐ COPD – Breathing problems
- ☐ ☐ Snoring or sinus problems
- ☐ ☐ Sleep Apnea
- ☐ ☐ Glaucoma
- ☐ ☐ Tuberculosis
- ☐ ☐ Artificial joints (date:_____)
- ☐ ☐ Herpes (Cold sores)

Y N
- ☐ ☐ Diabetes (HbA1c =_____)
- ☐ ☐ Digestive disorders
- ☐ ☐ Stomach or duodenal ulcer
- ☐ ☐ Acid/gastric reflux
- ☐ ☐ Celiac disease
- ☐ ☐ Crohn"s disease (celiac disease, gastric reflux.
- ☐ ☐ Caner (abnormal growth)
- ☐ ☐ Radiation Therapy
- ☐ ☐ Chemotherapy
- ☐ ☐ Hepatitis (A B C) A
- ☐ ☐ HIV/AIDS
- ☐ ☐ Arthritis/Rheumatoid Arthritis/Lupus
- ☐ ☐ Osteoporosis / Osteopenia

Meds
- ☐ ☐ Bisphosphonates
- ☐ ☐ Fosamax
- ☐ ☐ Aredia
- ☐ ☐ Phen Fen
- ☐ ☐ Kidney disease
- ☐ ☐ Liver disease
- ☐ ☐ Thyroid disease
- ☐ ☐ Dizziness/Fainting

Y N
- ☐ ☐ STI/STD
- ☐ ☐ Neurological Disorders (ADHD)
- ☐ ☐ Epilepsy or Seizures
- ☐ ☐ Psychiatric Care
- ☐ ☐ Anti-depressants
- ☐ ☐ Alcohol
- ☐ ☐ Recreational drugs
- ☐ ☐ Drug addiction
- ☐ ☐ Smoking (all forms)
- ☐ ☐ Cosmetic Surgery
- ☐ ☐ FEMALE – Birth control
- ☐ ☐ FEMALE – Pregnant (1st / 2nd / 3rd)
- ☐ ☐ MALE – Prostate disorder

Are you allergic to any of the following?
- ☐ ☐ Aspirin/Ibuprofen/NSAIDS
- ☐ ☐ Acetaminophen
- ☐ ☐ Penicillin/Erythromycin
- ☐ ☐ Sulfa
- ☐ ☐ Metals (gold/silver/copper/nickel)
- ☐ ☐ Latex
- ☐ Other:_____

Are you taking any medication?

Drug:_____Purpose:_____

Drug:_____Purpose:_____

Drug:_____Purpose:_____

Are there any other medical conditions you have that are not listed?

_____

_____

Name of Physician:_____

Specialty of Physician:_____

Purpose of recent physical exam?_____

Most recent findings?_____

Patient (Guardian) Signature: _____**Date**: _____

Doctor Signature: _____**Date**:_____

Patient Signature	**Date**	**Doctor**	**Date**

Patient Signature	**Date**	**Doctor**	**Date**

Informed Consent

1. **Examinations and X-rays:** I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan.

2. **Drugs, Medications, And Sedation:** I have been informed and understand that antibiotics and other medications can cause allergic reaction causing redness and swelling of tissues, pain, itching, vomiting, and or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given to me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

3. **Changes In Treatment Plan:** I understand that during treatment it may be necessary to change 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. I give my permission to the Dentist to make any/all changes and additions as necessary.

4. **Temporomandibular Joint Dysfunction (TMD):** I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility.

5. **Fillings:** I understand that care must be exercised in chewing on filling during the first 24 hours to avoid breakage. I understand that sensitivity is a common after effect of newly placed filling.

6. **Removal of Teeth:** Alternatives to removal have been explained to me (root canal therapy, crowns and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and 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 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.

7. **Crowns, Brides, Caps, Veneers and Bonding:** 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 that the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation. It has been explained to me that, in a very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may effect tooth surfaces and may require modification of daily cleaning procedures.

8. **Dentures Complete or Partial:** I realize that full or partial dentures are artificial, constructed of plastic, metal, and or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (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.

9. **Endodontic Treatment (Root Canal):** I realize there is no guarantee that root canal treatment will save may 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.)

10. **Periodontal Treatment (Scaling and Root Planing) / Prophylaxis:** I understand that I have a serious condition causing gum inflammation and or bone loss, and that it can lead to loss of my teeth. Alternative treatment plan have been explained to me, including non-surgical cleaning, gum surgery, and or extraction of teeth. I understand the success of any treatment depends in part on my effort to brush and floss daily, receive regular cleaning as directed, follow a healthy diet, avoid tobacco products and follow other recommendations.

I understand that dentistry 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 dental treatment which I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist other than the treating Dentist nor Bristol Dental & Orthodontics, is responsible for my dental treatment. I acknowledge the receipt of and understand the postoperative instruction and have been given an appointment date to return. I have received the Dental Materials Fact Sheet.

Signature of responsible party or patient (Parent if patient is a minor) Date

Bristol Dental & Orthodontics
2835 S. Bristol St. Ste A
Santa Ana, CA 92704
T: 714-754-1888
F: 714-754-0888

Appointment Cancellation Policy

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:

We require that you give our office 48 hours notice (2 days notice) in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of $50.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.

Additionally, if a patient is more than 20 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the $50.00 cancellation fee will be charged.

20 minutes late to an appointment = missed appointment

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have. We thank you for your patronage.

Missed hygiene (cleaning) appointment	***$50 fee***
Missed doctor (treatment) appointment	***$75 fee***
Missed specialist (treatment) appointment	***$125 fee***

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice. I have received a copy of Bristol Dental & Orthodontics Cancelation Policy.

Signature Date