La Meṣa Dental

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

Patient Information *(Please Print)*

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 ______________________ Social Security # ______________ Birthdate ____________
First MI Last

Address ______________________ City ______________ State __________ Zip ________

Home phone # ______________ Work phone # ______________ Cell phone # ______________

E-mail # ______________________________ Drivers Lic. # ______________

Name of employer ______________________ Occupation ______________

Whom may we thank for referring you to us? ______________________________

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 # ______________

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 Dental 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 $15 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: ______________

Dental History

Former Dentist ____________________ Phone # ____________

Reason for today's visit ____________________

Date of last exam/xray ____________ How often do you brush? ____________ How often do you floss? ____________

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

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold / hot
- ☐ Stain / discolored teeth
- ☐ Sensitivity to sweets or biting
- ☐ Sores or growths in your mouth

Medical History

Physician ____________________ Phone # ____________ Date of last visit ____________

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 ever taken - Redux or Phen/Phen? ☐ Yes ☐ No Last date taken ____________

Have you ever taken Coumadin? ☐ Yes ☐ No ☐ Daily Last taken ____________ Do you take Aspirin daily? ☐ Yes ☐ No

(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	☐	☐	Hepatitis-Type A, B, C	☐	☐	Respiratory Disease
☐	☐	Arthritis, Rheumatism	☐	☐	Cough, Persistent	☐	☐	Herbal Supplements	☐	☐	Rheumatic Fever
☐	☐	Artificial Heart Valves	☐	☐	Cough up blood	☐	☐	High Blood Pressure	☐	☐	Scarlet Fever
☐	☐	Artificial Joints	☐	☐	Diabetes	☐	☐	HIV Positive	☐	☐	Shortness of Breath
		Date ________	☐	☐	Epilepsy	☐	☐	Jaw Pain	☐	☐	Skin Rash
☐	☐	Asthma	☐	☐	Fainting	☐	☐	Kidney Disease	☐	☐	Stroke
☐	☐	Back Problems	☐	☐	Glaucoma	☐	☐	Latex Allergy	☐	☐	Swelling of Feet/Ankles
☐	☐	Blood Disease	☐	☐	Headaches	☐	☐	Liver Disease	☐	☐	Thyroid Problems
☐	☐	Cancer	☐	☐	Heart Murmur	☐	☐	Mitral Valve Prolapse	☐	☐	Tobacco Habit
☐	☐	Chemical Dependency	☐	☐	Heart Problems	☐	☐	Nervous Problems	☐	☐	Tonsillitis
☐	☐	Chemotherapy	☐	☐	Hemophilia	☐	☐	Pacemaker	☐	☐	Tuberculosis
☐	☐	Circulatory Problems			Describe ________	☐	☐	Psychiatric Care	☐	☐	Ulcer
					________	☐	☐	Radiation Treatment	☐	☐	Venereal Disease/STD

Authorization

I authorize my insurance company to pay 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

Date	Initial	

La Mesa Dental

I voluntarily and knowingly request and consent to the services, treatments and/or procedures recommended by the dentist and to all diagnostic methods deemed appropriate by the dentist which include, but not limited to, x-rays, study models, imagery, and other aids. I authorize the dentist to perform all such services, treatments and/or procedures and to utilize all diagnostic methods. Further I acknowledge and understand that the dentist may engage the assistance of others in performing such services, treatments and/or procedures and in utilizing such diagnostic methods.

I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the services, treatments, procedures and/or diagnostic methods that have been recommended.

I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by the dentist and others. I acknowledge that any insurance coverage that I may have is based on a contract between my insurance company and me, my spouse and/or my employer. The dentist is not party to this contract and the services, treatments, procedures and/or diagnostic methods are provided to me. Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatments, procedures and/or diagnostic methods provided to me. As a courtesy to me, the dental office will bill my insurance company and I acknowledge that I will remain liable for any amounts not paid by the insurance company for any reason (including but not limited to the insurance company declining coverage after initially approving it) or if the insurance company fails for any reason to reimburse the dentist within 30 days after being billed by the dentist. I acknowledge that it is my responsibility to provide the dentist with my current insurance information and any changes thereto.

All returned checks will be subject to a $25 returned check fee. Any account balances that remain unpaid for 60 days from the date of service shall accrue interest at the rate of 1½ percent (18%) per year and maybe referred to a collection company or attorney. In the event this occurs, I understand that I will be liable for collection costs of $50. Further, in the event any unpaid account balance is referred to an attorney for collection, I agree also to be responsible for all costs and reasonable attorney's fees incurred in connection therewith.

I consent to the dentist's use and disclosure of my health information to my insurance company and any agent thereof. I hereby assign to the dentist all of the insurance benefits due to me for services, treatments, procedures and/or diagnostic methods provided to me and I authorize my insurance company to make payment directly to the dentist for the cost associated therewith.

I further consent to be contacted by the dentist, any agent of the dental office, or collection agency (or agent thereof) or attorney to whom an unpaid account balance has been assigned or referred by mail to any address that I provide to the dental office and/ or by facsimile, email or phone number (whether a cell phone or landline) that I provide to the dental office.

Patient Signature: ______________________________ Date______________

Print Name: ______________________________

Guardian/Responsible Party, If minor: ______________________________ Date______________

Print Name: ______________________________

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)

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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 ______________________