LAST ____________ FIRST ____________

Today's Date ____________

PERSONAL DATA AND MEDICAL HISTORY

Your answers here are for our records only, and will be held in confidence.
During your initial visit, you may be asked followup questions based on your answers below.

SSN ____________
DOB ____________
Height ________ Weight ________
Occupation ____________

□ Single □ Married/Partner
□ Divorced □ Widowed
Spouse/Partner Name ____________

Street ____________
City, State ____________
Zip ____________
Phone (Provide one or more and please check preferred)
□ Home ____________
□ Business ____________
□ Cell ____________
Email ____________

Emergency Contact ____________ Emergency Phone ____________
If you are completing this for someone, what is your relationship to them? ____________
How did you hear about our practice? ____________

Allergies

Please check any of the following if you are allergic.

□ Local anesthetic □ Barbiturates, sedatives, sleeping pills □ Codeine or other narcotics
□ Penicillin and similar □ Aspirin □ Latex
□ Sulfa drugs □ Iodine □ Other ____________

Medical History

- Are you in good health? □ Yes □ No
- Has there been any change in your general health within the past year? □ Yes □ No
- Date of last physical exam ____________
- Are you now under the care of a physician? □ Yes □ No
- If so, what is being treated? ____________
- Physician Name and Address ____________
- Have you had serious illness or been hospitalized within the past 5 years? □ Yes □ No
- Are you taking any prescription or over the counter medicines? □ Yes □ No

If yes, which medicines? ____________

- Do you wear contact lenses? □ Yes □ No
- Do you wear a removable dental appliance? □ Yes □ No

Women:

- Are you pregnant? □ Yes □ No
- Do experience any problems related to your menstrual cycle? □ Yes □ No
  If so, please explain ____________
- Are you Nursing? □ Yes □ No
- Are you taking birth control medication? □ Yes □ No

LAST ____________________ FIRST ____________________

Today's Date ______________

PERSONAL DATA AND MEDICAL HISTORY (cont'd)

All patients: please check any of the following that apply to you, either at present or in the past.

- ☐ Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease
- ☐ Cardiovascular disease, heart trouble, heart attack, angina pressure, arteriosclerosis, stroke
- ☐ Chest pain upon exertion
- ☐ Short of breath after mild exercise or when lying down
- ☐ Swelling of ankles
- ☐ Cardiac pacemaker
- ☐ Allergy
- ☐ Sinus trouble
- ☐ Asthma or hay fever
- ☐ Fainting spells or seizures
- ☐ Persistent diarrhea or recent weight loss
- ☐ Diabetes
- ☐ Hepatitis, jaundice, liver disease
- ☐ HIV or AIDS infection
- ☐ Thyroid problems
- ☐ Respiratory problems, emphysema, bronchitis
- ☐ Arthritis or painful swelling of joins
- ☐ Stomach ulcer or hyperacidity
- ☐ Kidney trouble
- ☐ Tuberculosis
- ☐ Persistent cough or cough that produces blood
- ☐ Persistent swollen glands in neck
- ☐ Low blood pressure
- ☐ Sexually transmitted disease
- ☐ Epilepsy or other neurological disease
- ☐ Mental health problems
- ☐ Cancer
- ☐ Immune system problems
- ☐ Abnormal bleeding
- ☐ Blood transfusion
- ☐ Anemia or other blood disorders
- ☐ Ever been treated for tumor or growth

Dental Concerns

- Do any of your teeth bother you? ☐ Yes ☐ No

If yes, please indicate the location with an X below:

Upper Left	Upper Right
Lower Left	Lower Right

- Do you or your partner snore? ☐ Yes ☐ No
- Do your gums ever bleed? ☐ Yes ☐ No
- Do you smoke or use tobacco? ☐ Yes ☐ No

If yes, what type and how much?

____

- Do you use dental floss? ☐ Yes ☐ No
- Do you ever have mouth pain? ☐ Yes ☐ No
- Do you suffer from bad breath? ☐ Yes ☐ No
- Primary source of drinking water (please check one) ☐ Bottled ☐ Tap ☐ Filtered Tap

Please use this space to add anything else you wish to share with your dentist.

I certify that I have read and understand the above inquiries. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any Center for Cosmetic Dentistry staff member, responsible for any errors or omissions that I might have made in the completion of this form.

Patient or legal guardian signature **Date**

Please print name of guardian, if applicable:

LAST ____________________ FIRST ____________________

Today's Date ____________

SMILE EVALUATION :)

You are welcome to add additional information or explanation to any question in the space below it.

Do you like the way your teeth look? ☐ Yes ☐ No

Are you happy with the color of your teeth? ☐ Yes ☐ No

Would you like your teeth to be whiter? ☐ Yes ☐ No

Would you like your teeth to be straighter? ☐ Yes ☐ No

Do you have spaces between your teeth that you would like closed? ☐ Yes ☐ No

Would you like any of your teeth to be longer? ☐ Yes ☐ No

If so, where? ☐ Upper ☐ Lower ☐ Both

Do you like the shape of your teeth? ☐ Yes ☐ No

Do you have any missing teeth? ☐ Yes ☐ No

Would you like any silver fillings replaced with tooth-colored fillings? ☐ Yes ☐ No

If yes, please explain.

If you could change anything about your smile, what would you change?

LAST ____________________ FIRST ____________________

Today's Date ______________

CONSENT TO GENERAL DENTAL TREATMENT

I hereby authorize Dr. Robert Rioseco and/or Dr. George Rioseco and whomever they may designate as their assistants, to perform upon me (or the person for whom I am legal guardian) any and all dental procedures including but not limited to the following: Dental x-rays and other diagnostic procedures, model making, injection of local anesthetics and anesthetic reversing agents, placement or delivery of antibiotics either under gum tissue or by mouth or by injection/lavage, surgical manipulation of hard and soft tissues of the mouth including preparation of teeth for inlays, onlays crowns and fillings, surgical manipulation of the gums by blade or by laser, whitening of teeth and dispensing or home or in office whitening agents, root canal therapy as needed, extraction of teeth and placement of bone graft materials of various origins and membranes to facilitate effectiveness of said grafts.

I understand that dentistry is not always covered by insurance and that I am responsible for payment for these services, regardless of the outcome of insurance claims related to these services.

I understand that most dentistry involves removal of both healthy and unhealthy hard and soft tissues, and is essentially not reversible. I understand that the doctor will attempt to preserve as much of my natural tooth and bone structure while still achieving the desired effect, be that curative in nature or for cosmetic purposes.

The dentist has explained to me that as a result of manipulation of oral tissues and removal of tooth structure and /or gum tissue, I may experience any of--but not limited to--the following side effects: Loss of a tooth or teeth, damage of nerve tissue in a tooth or in multiple teeth resulting in need for root canal, pain in my teeth and surrounding tissues, teeth in one arch that do not perfectly match in color shape and size, with other teeth in that arch or in a the opposing arch, an esthetic result that is not entirely pleasing to me or other people, temporary or permanent pain in my jaws and or other TMJ related problems, problems with my bite, infection.

It has been explained to me by the dentist that any of these problems can occur and that adjunctive care may be necessary to correct them, and also that some of this damage may be permanent and irreversible. I understand that the dentist will be using injectable local anesthetics and that the use of local anesthetics has been shown in rare cases to cause temporary and/or permanent nerve damage. I am informed and I fully understand that inherent in any type of surgery are certain unavoidable complications. In oral surgery, the most common of these complications include post-operative bleeding, swelling and bruising, pain, stiffness of jaws loss or loosening of existing dental restorations. Other complications might include loss or injury to adjacent teeth and soft tissues, numbness to the lips mouth or face, jaw fractures sinus exposure and swallowing or aspiration of teeth, restorations and root fragments which might require further surgical intervention for removal.

I have provided as accurate and complete a medical history as possible and will follow any and all instructions explained to me by Dr. Rioseco and staff. I have had the opportunity to ask questions and provide input as to the outcome of my case and the risks and potential complications to the treatment offered. Alternate treatments including but not limited to orthodontics, minimal invasive techniques and cosmetic bonding have been offered to me prior to signing this form.

Patient/legal guardian's signature __________________________ **Date** __________

I have personally explained the above information to the patient or the patient's legal guardian.

Dentist signature __________________________ **Date** __________

Witness signature __________________________ **Date** __________

LAST ______________________ FIRST ______________________

Today's Date ______________

PATIENT HIPAA AWARENESS

With my permission, Robert Rioseco Family Dentistry may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Rioseco Family Dentistry's *Notice of Privacy Practices* for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Rioseco Family Dentistry reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Rioseco Family Dentistry may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Rioseco Family Dentistry may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and/or Confidential.

With my permission, the office of Rioseco Family Dentistry may e-mail to my email address any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Rioseco Family Dentistry restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Rioseco Family Dentistry to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Patient/legal guardian's signature ______________________ **Date** __________

I have personally explained the above information to the patient or the patient's legal guardian.

Dentist signature ______________________ **Date** __________

Witness signature ______________________ **Date** __________

LAST ____________________ FIRST ____________________

Today's Date ______________

STATEMENT ON INSURANCE PROCESSING

Although many dental offices are no longer handling insurance claims for their patients, we continue to provide insurance claim processing as a courtesy to our patients. This service is provided at no additional cost to you.

If a claim is denied by your insurance carrier, we will be happy to assist you in challenging it. However, it is not the responsibility of our office to determine whether or not a patient is covered under their insurance policy. It is strictly the patient's responsibility to review the "fine print" of their policy, and to make any and all necessary telephone calls in order to determine if the policy pays for treatment in this practice. Many insurance policies include a list of provider dentists, and require patients to seek treatment only with doctors who participate in the plan. This office has found that plans which offer "discount dentistry" do not allow us the freedom to treat our patients with the newest and most comprehensive methods; we therefore do not participate as providers in these sorts of plans. However, many of these types of plans offer some limited reimbursement on a modified benefits scale for patients who seek care out of network.

In the event of a disagreement with the insurance company, or in the case of any denied or delayed claims, payment of the balance is specifically and wholly the responsibility of the patient. Payment for all services must be made on the day the service is rendered, unless another agreement has been made with our staff. Patients are encouraged to accept the option of having their insurance company make direct reimbursement (where the monies are sent directly to the patients). Whether insurance payments are made to us or to the patient, payment is due on the day of service.

I, *(print name)* ______________________________, have read and fully understand the above statement. I have also been given the opportunity to ask questions I might have regarding the submission of insurance claims. I am aware that I am responsible for prompt settlement of my account with Dr. Rioseco regardless of the status of any insurance claims.

Patient/legal guardian's signature ______________________________ **Date** ______________

Please print name of legal guardian, if applicable: ______________________________

LAST ______________________ **FIRST** ______________________

Today's Date ______________

Cancellation Policy

As per office policy defined to me by Dr. Rioseco and/or his staff, I understand that by booking an appointment at The Center for Cosmetic Dentistry, I assume responsibility for attendance at said appointment.

Cancellation or rescheduling of any appointment with The Center for Cosmetic Dentistry, with notice shorter than 48 hours will result in a minimal charge of $285 per half-hour booked. This fee is non-refundable and cannot be applied to any other balance accrued at our practice, past or future.

Certain situations may arise which impede attendance at an appointment I have made, which will be left to the discretion of the doctor or office manager, when considering waiving this fee due to unforeseen conditions.

Of course, this policy does not apply to cancellations due to illness or inclement weather.

____

Patient Signature Month / Date / Year