Patient Information

Patient Name _____ Driver's License # _____

Address _____ City _____ State_____ Zip _____

Home Phone #_____Cell#_____ Work#_____

Social Security # _____ Date of Birth _____

Employer _____ Marital Statue (circle) married, single, widowed, divorced

Address _____ City _____ State _____ Zip _____

Occupation_____

Spouse's Name (Parent or Guardian if patent is a minor) _____

Social Security # _____ Date of Birth _____

Employer _____ Work Phone _____

Address _____ City _____ State_____ Zip _____

Person Responsible for Account If other than patient) _____

Address _____ City _____ State_____ Zip _____

Home Phone _____ Relation to Patient _____

Employer _____ Work Phone _____

In Case Of Emergency (nearest relative not living with you) _____Phone_____

FINANCIAL RESPONSIBILITY AGREEMENT

In consideration of treatment rendered to the above named patient, I accept full financial responsibility. Insurance forms will be completed as a convenience to the patient, however, payment to the doctor is expected at the time services are rendered, unless other arrangements are made in advance. I further agree that if this account is turned over to an attorney or collection agency, I will be responsible for all collection costs, interest of 21% APR, court costs and reasonable attorney fees.

X _____

Signature Relation to Patient if Minor Date

INSURANCE INFORMATION

(Please present your insurance card to the receptionist)

PRIMARY INSURANCE	SECONDARY INSURANCE
Insured's Name _____DOB_____	Insured's Name _____DOB_____
SS#_____Empl. ID#_____	SS#_____Empl. ID#_____
Insurance Co._____	Insurance Co._____
City _____State_____	City _____State_____
Ph.#(____)_____Group/Plan#_____	Ph.#(____)_____Group/Plan#_____
Effective Date _____ Relation to Patient_____	Effective Date _____ Relation to Patient_____
Insured's Employer_____	Insured's Employer_____
Address_____	Address_____

ASSIGNMENT OF INSURANCE BENEFITS: I herby authorize and request my insurance co. to pay directly to the Doctor the amount due on my claim for services rendered to me or my dependent. I understand that any amounts paid to this office are ESTIMATES only and I will not know the exact amount owed until my insurance has paid. I further agree that should the amount paid by my insurance be insufficient to cover the entire dental expense, I will be responsible for payment of the difference.

X _____ _____

Signature Date

CONFIDENTIAL HEALTH HISTORY

Patient Name _____ Sex: M F

Who referred you to our office? _____

Who is your Dentist? _____ City_____

Who is your Physician (Medical Doctor)? _____ City_____

1. Do you presently have a toothache? Yes ___ No ___
2. Have you had a previous Endodontic (Root Canal) Treatment? Yes ___ No ___
3. Are you in good health? _____
4. Are you currently under the care of a physician? Yes ___ No ___

   If yes, please explain: _____
5. If female, are you pregnant? Yes ___ No ___ What month? _____

   Do you anticipate becoming pregnant? Yes ___ No ___ Are you nursing? Yes ___ No ___
6. Have you ever had trouble with prolonged bleeding? Yes ___ No ___
7. Have you ever had an unusual or allergic reaction to a drug or medicine such as Penicillin, Erythromycin, Aspirin, Codeine, Novocaine, etc.? _____
8. Please list all medicines you are presently taking: _____

   _____
9. Is there any other information that we should know about your health? _____

   _____

DO YOU CURRENTLY HAVE OR PREVIOUSLY HAD ANY OF THE FOLLOWING?

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Heart Attack	☐	☐	Anemia	☐	☐	Diabetes	☐	☐	Epilepsy or Seizure
☐	☐	Heart Condition	☐	☐	Hemophilia	☐	☐	Glaucoma	☐	☐	Fainting or Dizzy Spells
☐	☐	Heart Murmur	☐	☐	Bleeding Disorder	☐	☐	Kidney Trouble	☐	☐	Nervous Disorders
☐	☐	Chest Pains (Angina)	☐	☐	Stroke	☐	☐	Liver Disease	☐	☐	Thyroid Disease
☐	☐	Heart Surgery	☐	☐	Bruise Easily	☐	☐	Hepatitis A (Infectious)	☐	☐	Cancer or Other Tumor
☐	☐	Artificial Heart Valve	☐	☐	Blood Transfusion	☐	☐	Hepatitis B (Serum)	☐	☐	Radiation Therapy
☐	☐	Heart Pacemaker	☐	☐	Lung Disease	☐	☐	Yellow Jaundice	☐	☐	Chemotherapy
☐	☐	High Blood Pressure	☐	☐	Shortness of Breath	☐	☐	Alcoholism	☐	☐	Cold Sores
☐	☐	Swelling of Ankles	☐	☐	Asthma or Hay Fever	☐	☐	Drug Addiction	☐	☐	Herpes
☐	☐	Rheumatic Fever	☐	☐	Tuberculosis (TB)	☐	☐	Arthritis or Rheumatism	☐	☐	Venereal Disease
☐	☐	Cortisone Medicine	☐	☐	Emphysema	☐	☐	Pain in Jaw Joints (TMJ)	☐	☐	AIDS (HIV+)
☐	☐	Joint Replacement	☐	☐	Latex Allergy	☐	☐	Fenfluramine or Dexenfluramine			

To the best of my knowledge, the above information is complete and accurate. If there is a change in my health or medicines, I will inform the Doctor at the next appointment.

_____ _____

Signature of: ☐ Patient ☐ Parent ☐ Guardian (check one) Date

MEDICAL CONDITION UPDATE:

_____

_____

_____

ENDODONTIC INFORMATION AND CONSENT

We would like our patients to be fully informed about the various procedures involved in endodontic therapy and we require their written consent before starting treatment. Endodontic (root canal) therapy is performed in order to save a tooth which otherwise might need to be removed. This is accomplished by conservative root canal therapy, or when needed, endodontic surgery. The following discusses possible risks that may occur from endodontic treatment, and other treatment choices.

GENERAL RISKS OF DENTAL CARE: Included (but not limited to) are complications resulting from the use of dental instruments and medicines such as; antibiotics, analgesics (pain killers), and local anesthetic injections. These complications may include; swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks and teeth, which is transient but on infrequent occasions may be permanent; reaction to injections, changes in occlusion (biting), jaw muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of teeth, referred pain to ear, neck and head, nausea, vomiting, allergic reactions, delayed healing, sinus perforations and treatment failure.

RISKS MORE SPECIFIC TO ENDODONTIC THERAPY: The risks include the possibility of instruments broken within the root canals, perforations (extra openings) or the crown or root of the tooth, damage to bridges, existing fillings, crowns or porcelain veneers, loss of tooth structure in gaining access to canals, and cracked teeth. During treatment complications may be discovered which make treatment impossible, or which may require corrective dental surgery. These complications may include; blocked canals due to fillings or prior treatment, natural calcifications, broken instruments, curved roots, periodontal disease (gum disease), splits or fractures of the teeth.

MEDICATIONS: Some prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers, sedatives or other drugs). It is not advisable to operate any vehicle or hazardous devise until recovered from their effects. Some antibiotics may interfere with the effectiveness of oral contraceptives (birth control pills). Women who are taking oral contraceptives, and are given a prescription for an antibiotic, are strongly advised to use additional means of birth control during the entire monthly cycle for which the antibiotic has been used.

OTHER TREATMENT CHOICES: These include no treatment, waiting for more definite development of symptoms, and tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth, and a spread of infection to other areas. The risks of these alternative treatments are often more severe than those of root canal therapy.

CONSENT: I, the undersigned, being the patient (parent or guardian of minor patient) consent to performing of the procedures decided to be necessary or advisable in the opinion of the doctor. I also understand that upon completion of the root canal therapy in this office I shall return to my general family dentist for a permanent restoration of the tooth involved, such as a crown, cap, jacket, onlay or filling.

I understand that root canal treatment is an attempt to save a tooth which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth which has had root canal therapy may require retreatment, corrective surgery or even extraction.

I hereby state that I have read and understand this consent. I have been given the opportunity to question the doctor, and all questions about the procedure(s) have been answered in a complete and satisfactory manner. This consent form doe not encompass the entire discussion I had with the doctor regarding the proposed treatment.

_____ _____

PATIENT / PARENT SIGNATURE DATE

JAMES S. SOCOLOSKE, DDS, INC.
355 Placentia Av., Suite 304
Newport Beach, CA 92663

PRIVACY NOTICE

In my dental office I consider it a high priority to earn and keep my patients' trust and confidence. My staff and I have always worked hard to maintain the highest standard of confidentiality, as well as respect the privacy of our patient relationships. In that regard, we are providing the PRIVACY NOTICE to all patients who are currently under our care, in accordance with the Health Insurance and Portability Act of 2003. This notice supplements any privacy policy or statements that our referring dentists, doctors, insurance companies or we may provide in connection with specific dental procedures or services.

THE INFORMATION WE COLLECT ABOUT YOU (THE PATIENT)

The non-public, personal information that we collect about you (your "information) comes primarily from the patient and insurance information worksheets, discussions or other forms you submit to us. We may also collect information (about your health history and surgeries, x-rays and insurance) relating to the services we provide from your other medical or dental offices. We urge our patients to provide us with all pertinent information to enable us to maintain patient and responsible party privacy. Having accurate information ensures that we will speak only with the correct parties about the dental procedure(s) or account.

OUR DISCLOSURE POLICIES

We do not disclose your information to anyone, except as permitted by law. This may include sharing your information with outside dentists, doctors, labs, pharmacies, collection and / or insurance companies that perform services for your dental procedure(s) or account. Additionally, it may include disclosing your information pursuant to your express consent, to fulfill your instructions or to comply with applicable laws and regulations.

OUR INFORMATION SECURITY POLICIES

We limit access to your information to those of our employees and care providers who are involved in your dental procedure(s) or administering services we offer. We maintain physical, electronic and procedural safeguards that are designed to comply with federal standards to guard your information. All employees are required to sign a confidentiality agreement as a condition of employment and to follow security policies and procedures. After the procedure(s), we will continue to treat the information as described in this PRIVACY NOTICE.

I HAVE READ AND AGREE TO THIS OFFICE POLICY.

Signature of patient: _____ Date: _____

(If you would like to read the full health information Privacy Policies and Procedures Act: The ten page policy is available to read at the front desk. Also, the four pages "Notice of Privacy Practices", which states more fully our Privacy Policies, is available as well.)