COASTAL IMAGE DENTAL
PATIENT REGISTRATION FORM

Email:____

PATIENT INFORMATION

Name: ____ DOB: ____/____/____ Age: _______ Sex: M / F
First Middle Last

Home Address: ____
Street City State Zip

Work Address: ____
Street City State Zip

Home Phone: _______________________ Work Phone: __________________ Cell Phone: __________________

SSN: _____________________ Driver's Lic: ___________________ Occupation: __________________________

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM PATIENT)

Name: ____SSN___________________________________

Address: ____DOB: ____/____/_____

Home Phone: ________________________ Work Phone: __________________ Cell Phone: __________________

INSURANCE INFORMATION (PLEASE PRESENT INSURANCE CARD AND DRIVER'S LIC. AT TIME OF CHECK-IN)

Insurance Name: ____

Insurance Address: ____

Name of Insured: _____________________________ Insured ID #__________________ Group #________________

Insured's SSN#______________________ DOB_______________________

Relationship of Patient to Insured: _____________________

In Emergency, Who May We Contact?

Name: ____Phone:__________________________________

Address: ____

Referred By: ____

Preferred Pharmacy (Name/ Phone):____

Do we have your permission to:

Leave a message on your answering machine at home?	☐ Yes	☐ No
Leave a message at your place of employment?	☐ Yes	☐ No
Discuss your medical condition with family?	☐ Yes	☐ No

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications, and prescriptions. I hereby assign my insurance benefits to be made directly to my physician for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member. I understand that I am responsible for knowing my benefits/coverage. I will be financially responsible for all charges that are not covered by my insurance company.

Patient or Responsible Party Signature: ____ Date: __________________

Coastal Image Dental Medical History

Patient Name: ____ Date: ______________

Are you allergic to any medications? ☐ Yes ☐ No If yes, list below:

____

Have you ever had dental anesthesia? ☐ Yes ☐ No Any bad reaction? ☐ Yes ☐ No

Has your doctor prohibited you from having epinephrine in dental anesthesia? ☐ Yes ☐ No
List all medications you are currently taking (including prescriptions, over-the-counter meds including aspirin, herbals, and vitamins):

____

____

Do you take any blood thinners like aspirin, coumadin, plavix, motrin, VitaminE? CIRCLE ☐Yes ☐No

Have you ever taken Fen-Pen, Redux, or Phentermine? CIRCLE ☐ Yes ☐ No

Do you have or have you ever had any diseases or conditions of: (Please Check YES or NO)

	YES	NO		YES	NO
High Blood Pressure	☐	☐	Diabetes	☐	☐
Heart Attack/Angina	☐	☐	Thyroid Disease	☐	☐
Heart Murmur	☐	☐	Urinary Disease	☐	☐
Pacemaker	☐	☐	Stomach Ulcers	☐	☐
Rheumatic Fever	☐	☐	Hepatitis	☐	☐
Mitral Valve Prolapse	☐	☐	Dialysis	☐	☐
Pacemaker	☐	☐	Arthritis	☐	☐
Artificial Valves	☐	☐	Artificial Joints	☐	☐
Asthma	☐	☐	Fainting	☐	☐
Shortness of Breath	☐	☐	Seizures	☐	☐
Tuberculosis	☐	☐	Stroke	☐	☐
Blood Clots	☐	☐	Migraines	☐	☐
Sinus Allergies	☐	☐	Depression	☐	☐
Cancer: Type? _____________ _	☐	☐	AIDS/HIV	☐	☐
Chemotherapy	☐	☐	Radiation Therapy	☐	☐
VD (syphilis or gonorrhea)	☐	☐	Nervous Disorders	☐	☐
Latex Sensitivity?	☐	☐			

List any other conditions: ____

List any major surgeries: ____

(Women) Are you currently nursing or pregnant? ☐ Yes ☐ No

DENTAL HISTORY:

Do you have any present dental complaints? ____________________________ What? ______________________

When was your last full-mouth X-ray? ________________________________ Where? _____________________

When was your last cleaning?______________________________________ Where?______________________

Have you ever been instructed in the prevention of decay? ____

Have you ever been instructed in caring for your gums? ____

Are you taking or have you ever taken Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Reclast, Forsamax, Actonel, Boniva, Aredia, Zometa? ☐ Yes ☐ No

SOCIAL HISTORY:

Do you drink alcohol? ☐ Yes ☐No If Yes____________ drinks per ☐ day ☐ week

Do you use IV drugs?☐ Yes ☐No If Yes, what? ____

Do you smoke? ☐ Yes ☐No If Yes, how much: ____

Have you had or been exposed to HIV/ AIDS? ☐ Yes ☐ No

What is your current occupation? ____

What are your current hobbies? ____

Completed by ☐ Patient Signature___________________________________ Date:____________

☐ Dental Assistant _______ Reviewed By: ______________________ Date: ___________

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy of contacting our office.

You have the right to request that we restrict how protected health information about you is used for disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices
- The Patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The Patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent.

This Consent was signed by: ____

Print Name – Patient or Representative

______________________________ ____/____/____

Signature Date

Relationship to Patient
(If other than patient): ____

Witness: ____

Print Name – Practice Representative

______________________________ ____/____/____

Signature Date

COASTAL IMAGE DENTAL

PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. However, before claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and co-payments. In the event, that your account is late past 60 days, a late fee of $20 will be added to your balance due each month. In the event that your account must be turned over to collections, a $25.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature: ______________________________ **Date**: _____________

PAYMENT POLICY:

PPO: You will be responsible for paying your annual deductible if not met and co-payments at time of service.

COMMERCIAL PATIENTS: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay 100% of the total bill at the time of the service. We will give you a copy of your bill to submit to your insurance for reimbursement.

Patient or Responsible Party Signature: ______________________________ **Date**: _____________

Coastal Image Dentistry

Appointment and Cancellation Policy for Appointments

Our goal is to provide quality care in a timely manner. In order to do so we have had to implement an appointment/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

Scheduled Appointments
For a scheduled appointment please call
949-863-0988 between the hours of 9:00AM and 5:00PM.

We encourage that you schedule regular appointments to maintain your health.

Cancellation of an Appointment
In order to be respectful of the needs of other patients, please be courteous and call our office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. This is how will help us best observe the needs for all of our patients.

If it is necessary to cancel your scheduled appointment we require that you call by 10 a.m. one (1) working day in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to Cancel Your Appointment
To cancel appointments please call 949-863-0988. If you do not reach the receptionist you may leave a detailed message on the voice mail. You may not cancel via email.

Late Cancellations
Late cancellations will be considered as a "no show". Any cancellations made after 10 a.m. one working day prior to the appointment will be subject to our No Show Policy.

No Show Policy
A "no show" is someone who misses an appointment without canceling it by 10 a.m. one (1) working day in advance. No-shows inconvenience those individuals who need access to dental care in a timely manner.

A failure to present at the time of a scheduled appointment will be recorded in the patients' chart as a "no show." The first time there is a "no show", the a fee of $25.00 will be billed to the patient. A second "no show" will result in a fee of $50 billed to the patient. After the third "no show," it will be left to the physician's discretion whether or not to issue the patient a discharge letter, disengaging the patient from the practice.

The patients' signature below indicates the patient has read and understands the above policy.

______________________________ ____________________

Patient Signature Date

Coastal Image Dentistry

Patient Acknowledgement of Receipt of Dental Materials Fact Sheet

I, ______________________________________, acknowledge I have
Please print name
received from the office of **DANIEL HUANG DDS, Inc.** a copy of the Dental Materials Fact Sheet dated October 2001.

____ ________________________
Patient Signature Date

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The following document is the Dental Board of California's Dental Materials Fact Sheet. The Department of Consumer Affairs has no position with respect to the language of this dental Material Fact Sheet; and it's linkage to the DCA webswite does not Constitute an endorsement of the content of this document.

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The Dental Board of California
Dental Materials Fact Sheet
Adopted by the Board on October 17, 2001

As required by Chapter 801, Statutes of 1992, the Dental Board of California has prepared this fact sheet to summarize information on the most frequently used restorative dental materials. Information on this fact sheet is intended to encourage discussion between the patient and dentist regarding the selection of dental materials best suited for the patient's dental needs. It is not intended to be a complete guide to dental materials science.

The most frequently used materials in restorative dentistry are amalgam, composite resin, glass ionomer cement, resin-ionomer cement, porcelain (cement), porcelain (fused-to-metal), gold alloys (noble) and nickel or cobalt-chrome (base-metal) alloys. Each material has its own advantages, benefits and risks. These and other relevant factors are compared in the attached matrix titled "Comparisons of Restorative Dental Materials. A Glossary of Terms" is also attached to assist the reader in understanding the terms used.

The statements made are supported by relevant, credible dental research published mainly between 1993-2001. In some cases, where contemporary research is sparse, we have indicated our best perceptions based upon information that predates 1993.

The reader should be aware that the outcome of the dental treatment or durability of a restoration is not solely a function of the material from which the restoration was made.

The durability of any restoration is influenced by the dentist's technique when placing the restoration, the ancillary materials used in the procedure, and the patient's cooperation during the procedure.

Following restoration of the teeth, the longevity of the restoration will be strongly influenced by the patient's compliance with dental hygiene and home care, their diet and chewing habits.

COASTAL IMAGE Dental

INFORMED CONSENT

CHART NUMBER: ________________ DANIEL HUANG DDS, Inc.

NAME: ____________________________________

1. WORK TO BE DONE

I understand that I am having the following work done: Fillings_______, Bridges_______, Crowns_____, Extractions______, Impacted teeth removed______, Root Canals_______, Dentures______, X-Rays______, Other____

(Initials________)

2. DRUGS AND MEDICATIONS

I understand that antibiotics and analgesics and other medications can cause allergic reactions (Initials________)

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. For example, root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary. (Initials________)

4. 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 other necessary for reasons in paragraph #3. 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 (Parasthesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.

(Initials________)

5. CROWNS, BRIDGES AND CAPS

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 more cementation. It is also my responsibility to return for permanent cementation within 30 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge or cap. I understand there will be additional charges for remakes due to my delaying permanent cementation.

(Initials________)

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 root canal filing material may 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). I understand that the tooth may be lost despite all effort to save it.

(Initials________)

7. PERIODONTAL LOSS (TISSUE & BONE)

I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead o the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand there is no guarantee that any of these procedures alone will prevent future loss of teeth.

(Initials________)

8. FILLINGS

I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly place filling. (Initials________)

9. DENTURES

I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate dentures (placement of dentures immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of more than 30 days there will be additional charges. (Initials________)

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 hereby authorize any of the doctors or dental auxiliaries of Daniel Huang DDS, Inc. to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosed circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation. Should any dispute arise over dental services provided to me, that is whether any dental service rendered was allegedly unnecessary unauthorized or was improperly, negligently, or incompetently performed, said dispute will be submitted to Peer Review by the local component of The American Dental Association. The decision of Peer Review shall be binding on both parties. I have read, understood, and agreed to the above.

Signature: ________________________________ Date: ______________________________

Doctor: __________________________________ Witness: _____________________________