Xceptional Dental
Janette Carsen D.M.D.

Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form completely.
If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information (Confidential)

Today's Date: ______ - ______ - ______

Patient Full Legal Name: ____________________________ I prefer to be called: ________________

Address: ______________________ (Street) ______________ (City) ______________ (State) ________ (Zip Code)

Cell Phone: ________________Y__N_ (Ok to receive text?) Home/2nd phone: ______________ _______ - ______ - ______ (Birthdate)

Email: ____ _______ - ______ - ______ (Social Security Number)

Employer: ______________________ (Company Name) ______________ (Work Phone) ______________ (Work email Address)

Employers Address: ______________________ (Street) ______________ (City) ______ (State) ________ (Zip Code)

If Patient is a Student: ______________________ (Name of School / College:) FT / PT ______________ (City) ______ (State)

Whom do we have your permission to share your health & financial records with? ____________________

How did you learn about our office? ____

Person to Contact in Case of Emergency: ______________ (Name) ______________ (Relationship) ______________ (Phone)

Nearest Relative Not Living With You: ______________ (Name) ______________ (Relationship) ______________ (Phone)

Dental Health History

Your answers to this dental health questionnaire will help us to understand your specific dental situation, so that we may more effectively treat you with consideration for your individual needs.

Previous Dentist: ____________________ Date of Last Visit ___ /___ /___ Date of Last Complete Dental Exam ___ /___ /___.

What is your immediate dental concern? ____

Yes ☐ No ☐ 1. Are you troubled with dryness in your mouth?
Yes ☐ No ☐ 2. Have you had Periodontal treatment, gum surgery, Root Planning & scaling or "deep cleaning"?
When:____________________ Where:________________ circle which treatment(s) was rendered
Yes ☐ No ☐ 3. Have you been informed that you have gum problems?
Yes ☐ No ☐ 4. Do your gums bleed when you brush your teeth or floss?
Yes ☐ No ☐ 5. Does food catch between your teeth?
Yes ☐ No ☐ 6. Are you aware of a bad taste or odor in your mouth?
Yes ☐ No ☐ 7. Do your jaw muscles feel tired, stiff or painful?
Yes ☐ No ☐ 8. Are you aware of clenching your teeth during the day?
Yes ☐ No ☐ 9. Have you ever been told that you grind your teeth during sleep?
Yes ☐ No ☐ 10. Have you ever cracked or broken a tooth?
11. Which Items do you use daily? (circle) Hard bristle toothbrush - Soft bristle toothbrush - Electric toothbrush - Proxi-brush - Rubber tip - Dental floss – Waterpic - Other __________

Please select *one* box on *each* line

☐ My mouth is very comfortable ☐ My mouth is moderately comfortable ☐ My mouth is uncomfortable
☐ My smile is excellent ☐ I would like to change my smile ☐ I am unconcerned about my smile
☐ I will do whatever I must to keep my teeth ☐ I want to keep my teeth but work within a budget of time & money
☐ I've done the dentistry recommended to me ☐ I've NOT done the recommended dentistry ☐ Never been recommended
MY DENTAL HEALTH IS: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

MEDICAL Health History

Patient **NAME**:____________________

Physician:____________________________ **Office Phone:**________________ **Date of Last Exam:**_______

All drugs (including recreational drugs such as Cocaine, Marijuana, Stimulants or Depressants) may have a fatal interaction with local anesthetics or other common dental medications. Please describe the use of any drugs or discuss in complete confidentiality with the doctor.

	Yes	No
Are you under medical treatment now?	☐	☐
Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
Are you taking any medications? Including non-prescription herbs or supplements	☐	☐
If yes, please list those medications: ____________________		
Do you use tobacco/tobacco products (including e-cigs)	☐	☐
Do you use marijuana?	☐	☐
Do you use cocaine or other recreational drugs?	☐	☐

	Yes	No
Have you taken Phen-fen?	☐	☐
Are you allergic to, or have you had any reactions to the following?		
Local Anesthetics (e.g., novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Rubber or Latex	☐	☐
Other (specify): ____________________	☐	☐

Women Only

	Yes	No
Are you pregnant or think you may be pregnant?	☐	☐
Are you taking birth control pills?	☐	☐

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

	Yes	No		Yes	No		Yes	No
AIDS Related Complex	☐	☐	Glaucoma	☐	☐	Osteoporosis	☐	☐
Alcohol or Drug Dependency	☐	☐	Heart Attack	☐	☐	Pacemaker	☐	☐
Anemia	☐	☐	Heart Disease	☐	☐	Prolonged Bleeding	☐	☐
Angina	☐	☐	Heart Murmur	☐	☐	Prolonged Cough	☐	☐
Arthritis	☐	☐	Heart Surgery	☐	☐	Psychiatric Treatment	☐	☐
Artificial Heart Valves	☐	☐	Hepatitis	☐	☐	Radiation Therapy	☐	☐
Artificial Joints	☐	☐	Herpes	☐	☐	Rheumatic Fever	☐	☐
Asthma	☐	☐	High Blood Pressure	☐	☐	Sinus Problems	☐	☐
Cancer	☐	☐	HIV	☐	☐	Stroke	☐	☐
Chemotherapy	☐	☐	Jaundice	☐	☐	Thyroid Disease	☐	☐
Congenital Heart Lesions	☐	☐	Kidney Disease	☐	☐	Tuberculosis	☐	☐
Diabetes	☐	☐	Liver Disease	☐	☐	Ulcers	☐	☐
Epilepsy	☐	☐	Mitral Valve Prolapse	☐	☐	Venereal Disease	☐	☐
Fainting	☐	☐	Organ Transplant	☐	☐	Other (specify) ____________		

Please add anything you feel is important for us to know about your dental or medical history:______________________

____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. If I have any changes in my health, or if my medications change, I will inform the doctor at the next appointment. If deemed advisable, I grant permission for my physician to be contacted for details and advice.

I authorize the taking of radiographs, photographs, or other diagnostic measures appropriate for a thorough evaluation. I consent to any necessary services needed during diagnosis and treatment. I grant permission to use my diagnostic and treatment photographs, models and records for the purpose of display for scientific articles, seminars and presentations provided that my identity is not revealed.

I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

______________________________ ____-____-____

Signature of Patient (or Parent if Minor) Date

Doctor's Comments: ____

____

____

______________________________ ___/___/___

Signature of Doctor Date

Reviewed / Date Reviewed / Date Reviewed / Date Reviewed / Date Reviewed / Date Reviewed / Date Reviewed / Date

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Appointments

Missed appointments, or those cancelled with less than 48 business hours of the scheduled appointment time, will be charged a minimum $50 appointment fee.

We believe that we can provide optimal dental care only if we have enough time to thoroughly examine your condition and discuss any treatment options.

Your appointment is reserved exclusively for you. If you miss or fail to attend your appointment or cancel at the last moment, we will be unable to care for another patient.

We ask that you arrive promptly for your appointment so that the allotted time can be spent with you.

If you arrive 10 or more minutes late for your appointment, we may need to reschedule your appointment to allow us to stay on time for our other scheduled patients. This is considered a “missed appointment”.

If you think that you may be late for your appointment, please call us as soon as possible so that we may advise you if your late arrival can be accommodated, or if we will need to reschedule your appointment and assess a fee.

We respect your time as well, and in the event that we have unforeseen issues and will be running late, we will attempt to notify you. This is why we ask for the “best” number/manner to reach you on short notice.

We realize that there can be circumstances beyond (y)our control and we always take that into consideration.

If you do not agree with our appointment policy, we ask that you be seen on a “call-first” basis, rather than pre-appoint for a time you may not be able to honor.
Excessive late or missed appointments can result in the termination of the Doctor/patient relationship.

I understand and consent to a fee being assessed in the unlikely event that I am unable to honor a prescheduled appointment (A “missed appointment”).
My signature indicates that I will remit the missed appointment fee before scheduling my next appointment.

______________________________ Signature

__________ Date

______________________________ PRINTED NAME

Financial Policy & Insurance Information

Xceptional Dental
Janette Larsen D.M.D.

Patient Name: ____________________

INSURANCE

Responsible Party *(If different from patient)* Relationship to Patient:____________________

Name: ____________________ ____________ ____________ __/__/__
Phone Social Security # Birthdate

Address: ____________________ ____________ ______ ______
Street City State Zip Code

Employer: ____________________ ____________ ____________
Company Name Work Phone eMail Address

Business Address: ____________________ ____________ ______ ______
Street City State Zip Code

Primary Insurance Information Subscriber relationship to Patient: ____________

____________________ ____________ ____________ ____________
Insurance Company Phone Group Number Subscriber/ID #

Address: ____________________ ____________ ______ ______
Street City State Zip Code

Secondary Insurance Information *Do you have additional insurance? (e.g., from spouse)* ☐ ***Yes*** ☐ ***No***

If Yes, complete the following:

Insured: ____________________ ____________ ____________ __/__/__
Name Phone Social Security # Birthdate

Employer: ____________________ ____________ ____________
Company Name Work Phone Insured's Relationship to patient

____________________ ____________ ____________ ____________
Insurance Company Name Phone Group Number Subscriber/ID #

Address: ____________________ ____________ ______ ______
Street City State Zip Code

Insurance Authorization and Release

I authorize and request my insurance company to assign insurance benefits to (check one):

______ I will pay Dr. Larsen in full at each visit and my Insurance Co will pay any reimbursements directly to Me.

______ I will pay my estimated co-insurance to Dr. Larsen at the time of my visit. My insurance shall Pay to Dr Larsen. Any difference remaining between the estimated insurance coverage and actual payment made by insurance will be invoiced (or reimbursed) to me upon completion of insurance processing, typically within 45 days from the date of service. Any unpaid balances exceeding 30 days are subject to 1.0% interest monthly, limited to 12% per year.

I understand that my dental insurance is an agreement between me (or my employer) and the insurance company carrier, NOT between Dr. Larsen and the insurance company. My insurance may pay less than the actual bill or estimated portion for services and neither Dr. Larsen nor the insurance company can or will promise the insurance payment amount.

I have read, understand and agree to the Financial Policies contained herein: *(Responsible Party)*

Our office, as most businesses, requires payment in full for all services rendered at the time of visit. If you have insurance, we are pleased to be able to provide insurance billing service to you, and as a courtesy, you may have the insurance pay the office directly.

You may pay for services using cash, personal check, Visa/MC, Discover & American Express.
Additionally, we offer CareCredit™ as an alternative for monthly payments if you qualify.

In the event a balance remains on account more than 30 days, balance is subject to 1.0% interest monthly, limited to 12% per year. If account is not paid within 60 days of the date of service (including insurance portion if applicable), I will be responsible for legal fees, collection agency fees, interest charges, late fees and any other expenses incurred in collecting my account.

____________________ ____________________ ____________________
*Responsible Party **Printed** Name* *Signature* *Date*

Xceptional Dental
Janette Larsen D.M.D.

JANETTE LARSEN, D.M.D.
2044 Chatsworth Boulevard
San Diego, CA 92107
(619) 223-6767

NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

You have the Right to:

* Get a copy of your medical record
* Correct your medical record
* Request confidential communication
* Ask us to limit information we share
* Get a copy of this privacy notice
* Choose someone to act for you
* Get a list of those with whom we've shared
* File a complaint if you believe your privacy rights have been violated

Your Choices:
You have some choices in the way that we use & share information as we:

* Tell Family & Friends about your condition
* Provide disaster relief
* Include you in a hospital directory
* Provide Mental Health Care
* Raise Funds
* Market our services & sell our information

Our Uses and Disclosures:
We may use & share your information as we:

* Treat you
* Run our organization
* Bill for your services
* Help with public health & safety
* Do research
* Comply with the law
* Respond to organ/tissue requests
* Respond to lawsuits/legal actions
* Address workers' compensation, law & government agencies

NOTICE OF DENTAL MATERIALS

I understand that, according to the Dental Board of California (Business and Professions Code 1648.10-1648.20), I must have the opportunity to review a Dental Materials Fact Sheet **(ON THE BACK OF THIS PAPER)**. I understand that this information:

- Contains information regarding Allergic reactions, Safety and Toxicity to Dental Materials.
- Addresses Advantages and Disadvantages to a variety of Dental Materials.
- Instructs me to talk to my dentist and ask questions regarding dental materials so that I may make an informed choice.

The durability of any dental restoration is influenced not only by the material it is made from but also by the dentist's technique when placing the restoration. Other factors include the supporting materials used in the procedure and the patient's cooperation during the procedure. The length of time a restoration will last is dependent upon your dental hygiene, home care, diet and chewing and biting habits. ……www.dbc.ca.gov

I have received, read and understand the ***Notice of Privacy Practices AND Notice of Dental Materials***.

I understand that this organization has the right to change its ***Notice of Privacy Practices AND Notice of Dental Materials*** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the ***Notice of Privacy Practices AND Notice of Dental Materials.***

PRINT Patient Name: ___________________________________ Signature: ___________________________________

Date: ______________ Relationship to Patient: ___________________________ (if not signed by Patient)

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

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Dental Materials Summary Fact Sheet

Allergic Reactions to Dental Materials

Components in dental fillings may cause reactions just like other materials we come into contact with in our daily lives. The risk of such reactions is very low for all types of filling materials and there are no documented cases of allergic reactions to composite resin, glass ionomer, resin ionomer or porcelain. If you have allergies, discuss filling materials with your dentist.

Toxicity of Dental Materials

Dental Amalgam – not used in this office

Mercury in its *elemental* form is on the State of California's Prop 65 list of chemicals known to the State to cause reproductive toxicity. The FDA and other public health organizations have investigated the safety of amalgam used in dental fillings and there is no valid scientific evidence that has shown harm to patients with amalgam dental restorations (except rare allergy.)

Composite Resin

Some Composite Resins include Crystalline Silica, which is on the State of California's Prop 65 list of chemicals known to the State to cause cancer.

Advantages	Disadvantages
Composite Resin (tooth colored) Fillings	
Strong & durable	Moderate occurrence of tooth sensitivity
Tooth colored	Costs more than dental amalgam
Resists breaking	Material can shrink or leak over time
Maximum amount of natural tooth preserved	May wear faster than surrounding natural tooth
Frequency of repair or replacement is low to moderate	Requires more than one visit for inlays & crowns
Glass-Ionomer Cement	
Reasonably good esthetics	Cost is similar to Composite Resin
May provide some help against decay	Limited Use-not for biting surfaces in permanent teeth
Low incidence of tooth sensitivity	Does not wear well- cracks and becomes rough
Resin-Ionomer Cement	
Very Good esthetics	Cost is similar to Composite Resin
May provide some help against decay	Limited Use-not for biting surfaces in adults
Good resistance to leakage	Wears faster than Composite Resin
Porcelain (Ceramic)	
Resistant to surface wear-can cause wear on opposing teeth	Material is brittle and can break under biting forces
Good resistance to further decay	May not be recommended for all teeth/patients
Resists leakage because it can be shaped for accurate fit	
Does not cause tooth sensitivity	
Porcelain fused to Metal (PFM)	
Good resistance to further decay with proper fit	More tooth must be removed (than Porcelain)
Very durable, due to metal substructure	
Resists leakage, no tooth sensitivity caused	
Gold Alloy	
Good resistance to further decay with proper fit	Is not tooth colored
Excellent durability, does not fracture under biting pressure	Conducts heat and cold, may irritate sensitive teeth
Does not corrode, resists leakage	Cost can be higher than Porcelain or PFM