Xceptional Dental
JANETTE LARSEN, DMD

2044 Chatsworth Blvd.
San Diego, CA 92107
619-223-6767
Xceptional Dental.com

Thank You For Selecting Our Dental Healthcare Team!

We will provide you with the finest possible dental care.
To help meet all your dental healthcare needs, please fill out this form completely.
If you have any questions or need assistance, please ask us - we are happy to help.

Patient Information *(Confidential)*

Patient Full Legal Name: _____ I prefer to be called: _____

Address: _____ (Street) _____ (City) ____ (State) _____ (Zip Code)

Phone(s): _____ (Cell/Mobile Phone) ☐Y ☐N (Ok to receive text?) _____ (Home/2nd Phone) _____ (Work/Office Phone)

_____ (Email Address) ____ - ____ - _____ (Social Security Number) ____ - ____ - _____ (Birthdate (MM - DD – YYYY))

Employer: _____ Gender : _____

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

How did you learn about our office? _____

Emergency Contact: _____ (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–or have you been told of -clenching or grinding your teeth during the day?
Yes ☐	No ☐	9.	Are you aware of–or have you been told of -clenching or grinding your 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 & 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

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Medical Health History

Physician: _____ **Dr. 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: _____

_____

_____

	Yes	No
Do you use marijuana?	☐	☐
Do you use cocaine or other recreational drugs?	☐	☐
Do you use tobacco/tobacco products (including e-cigs)	☐	☐

Are you allergic to, or have you had any reactions to the following?

	Yes	No
Local Anesthetics (e.g., novocaine)	☐	☐
Rubber or Latex	☐	☐
Penicillin or other Antibiotics	☐	☐
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? ***PER CALIFORNIA LAW EACH QUESTION MUST BE MARKED INDIVIDUALLY***

	Yes	No
Alcohol or Drug Dependency	☐	☐
Anemia	☐	☐
Angina	☐	☐
Arthritis	☐	☐
Artificial Heart Valves	☐	☐
Artificial Joints	☐	☐
Asthma	☐	☐
Cancer	☐	☐
Chemotherapy	☐	☐
Diabetes	☐	☐
Depression or Mood Conditions	☐	☐
Epilepsy	☐	☐
Fainting	☐	☐
Gastric Reflux(GERD) / Heartburn	☐	☐
Glaucoma	☐	☐
Heart Attack/Surgery	☐	☐
Heart Disease	☐	☐
Including Coronary Artery Disease/ Artherosclerosis		
Hepatitis	☐	☐
High Blood Pressure	☐	☐
HIV	☐	☐
Jaundice	☐	☐
Kidney Disease	☐	☐
Liver Disease	☐	☐
Organ Transplant	☐	☐
Osteoporosis	☐	☐
Pacemaker	☐	☐
Prolonged Bleeding	☐	☐
Prolonged Cough	☐	☐
Radiation Therapy	☐	☐
Rheumatic Fever	☐	☐
Sinus Problems	☐	☐
Snoring *(or told you snore)*	☐	☐
Sleep Apnea	☐	☐
*If Yes, Did you try CPAP?	☐	☐
*Have you had a sleep study	☐	☐
Stroke	☐	☐
Thyroid Disease	☐	☐
Tuberculosis	☐	☐
Ulcers	☐	☐
STD/STI *incl* Herpes	☐	☐
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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Sleep Screening Questionnaire

(Why is Dr. Larsen asking about my sleep habits?)

There is often a correlation between breakdown of the teeth, TMJ disorders, clenching and sleep disorders. Sleep apnea may increase your risk for many significant health conditions including heart attack and stroke.

Name: _____ **Height:** _____ **Weight:** _____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

0 = I would never doze
1 = I have a slight chance of dozing
2 = I have a moderate chance of dozing
3 = I have a high chance of dozing

Situation	Chance of Dozing (low=0 - high=3)
1. Sitting and reading	_____
2. Watching TV	_____
3. Sitting inactive in a public place (e.g. a theater or a meeting)	_____
4. As a passenger in a car for an hour without a break	_____
5. Lying down to rest in the afternoon when circumstances permit	_____
6. Sitting and talking to someone	_____
7. Sitting quietly after lunch without alcohol	_____
8. In a car while stopped for a few minutes in traffic	_____

Total Score _____

Are you aware of (or have you been told):	Yes	No
1. Snoring on a regular basis	☐	☐
2. Feeling tired or fatigued on a regular basis	☐	☐
3. Clenching or grinding your teeth (bruxism)	☐	☐
4. Having frequent headaches	☐	☐
5. Your neck size being > 17 inches (male) or > 16 inches (female)	☐	☐
6. Anyone in your family having sleep apnea	☐	☐
7. Stopping breathing when sleeping/awakening with a gasp	☐	☐
8. Impaired Cognition (i.e. difficulty concentrating or thinking)	☐	☐
9. Insomnia	☐	☐
10. Do you have difficulty breathing through your nose?	☐	☐
11. Are you a 'mouth breather' ?	☐	☐

For children only (filled out by parent or guardian)

Are you aware of your child:	Yes	No
1. Snoring/noisy breathing while sleeping	☐	☐
2. Grinding his or her teeth	☐	☐
3. Wetting the bed	☐	☐
4. Having difficulty in school/learning	☐	☐
5. Being treated for ADD or ADHD	☐	☐
6. Breathing primarily through their mouth	☐	☐
7. Having frequent ear aches	☐	☐

Dental Exam Findings: ☐ Evidence of Bruxism ☐ Scalloping of the tongue ☐ Crowded airway
☐ Tori or Bone Loss ☐ Anterior wear ☐ Retrognathia / Class II

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Appointment & Financial Policies

Appointment Policy

Missed appointments, or those cancelled with less than 48 business hours of the scheduled appointment time, will be charged a $60 missed-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. The same is true for treatment that has been scheduled.
- 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. 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.

Appointment Notification Protocol

- Our notification/reminder system will help you confirm upcoming appointments and provide efficient reminders. You may opt-out at any time.
- The information you provide us, such as email and cell phone numbers are a protected part of your health care record. We do not share nor release this information outside of this office. Your privacy is important to us.

Please check your preferred method for automated Appointment Reminders:

☐ Text Message ☐ Email Message ☐ Phone Message ☐ NONE

Financial Policy - Dental Benefit Plan Authorization & Release

I authorize and request my Dental Benefit Plan (DBP /insurance) to assign benefits to Dr. Larsen

I will pay my full payment or, if insured, my estimated co-insurance to Dr. Larsen at the time of my visit. If I have dental insurance, my Dental Benefit Plan (DMB/insurance) shall pay to Dr Larsen. Any difference remaining between the estimated DPB coverage and actual payment made by my DBP will be invoiced (or reimbursed) to me upon completion of insurance processing, typically within 45 days from the date of service.

I understand that my Dental Benefit Plan is an agreement between me (or my employer) and the DBP company carrier. My DBP may pay less than the actual bill or estimated portion for services and neither Dr. Larsen nor the DMB carrier can or will promise the ultimate insurance payment amount.

I have read, understand and agree to the Appointment & 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 a Dental Benefit Plan, we are pleased to be able to provide DBP claim filing services to you, and as a courtesy, you may have the DBP 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 45 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 dental benefit plan portion, if applicable). The undersigned will be responsible for legal fees, collection agency fees, interest charges, late fees and any other expenses incurred in collecting past-due account.

Responsible Party Printed Name	*Signature*	*Date*

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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