MILLIKEN DENTAL GROUP – RANCHO DENTAL OFFICE

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ❑ M ❑ F
Street address:	Social Security no.:	Home phone no.:«HmPhone» ( )			
P.O. box:	City:«City»	State:«State»	ZIP Code:«Zip»		
Occupation:	Employer:	Employer phone no.: ( )			
PLEASE WHO REFERED YOU TO US?	❑ Dr.	❑ Insurance Plan	❑ Hospital		
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other	
Other family members seen here:					

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )		
Is this person a patient here?	❑ Yes	❑ No			
Occupation:	Employer:	Employer address:	Employer phone no.: ( )		
Is this patient covered by insurance?	❑ Yes	❑ No			
Please indicate primary insurance	❑ DELTA	❑ AETNA	❑ PRINCIPAL	❑ GUARDIAN	❑ METLIFE
❑ CIGNA	❑ UNITED CONCORDIA	❑ Healthy Families	❑ DENTI-CAL *(Please provide card)*	❑ Other	
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Dentist. I understand that I am financially responsible for any balance. I also authorize my Dentist or insurance company to release any information required to process my claims.

Patient/Guardian signature ____________________ *Date* ____________________

DATE :   Patient :

Milliken Dental Group – Rancho Dental Office

Financial Policy

- Payment is due at the time services are rendered. We accept cash, and all credit cards. We will extend a 5% accounting courtesy for cash payments or 3% for credit card payments for treatment over $500 that is paid in full prior to treatment. To make dental treatment affordable, we also offer payment plans through Care Credit
- Some services may not be covered by your dental benefits company. The doctors make their recommendations based on their knowledge of what is best for your oral health, not on what your benefits will cover. Please don't allow the insurance company to determine what is best for you.
- Outstanding balances over 60 days are subject to collection fees and an interest rate of 1.75% per month.
- There will be a fee for any additional procedure NOT included in the original treatment plan.
- A fee of $85.00 and a signed Release Request form are required for duplicating x-rays requested by patient.
- Photos/Video: Our office procedure is that we may take photos/video of teeth being treated on and which we store in your chart as records and may be used for training / advertising purposes
- Our office procedure is to share P.H.I. with Dental / Medical labs, referring Dr's or Dentist, call a pharmacy of your choice. Only a minimum of necessary P.H.I. will be exchanged for each transaction.
- In order to improve our customer service our phone lines may be electronically monitored
- We charge 10% booking fee on refunds.
- If the patient is a minor, the adult on charge must not leave the premises during treatment
- We treat scanned documents as originals.
- We ask you to please respect other patient's privacy, due to the fact that our Dental office was designed before the HIPPA Law. Thank you.

Dental Insurance

- If you have dental benefits, we are happy to assist you in filing the necessary forms to help you receive the full benefits of your coverage; however, we can make no guarantee of any estimated payment. Because the dental benefits policy is an agreement between you and your benefits company, you are responsible for all charges. After your initial exam, you will receive a treatment plan which estimates your portion of payment. If we collect an estimated co-payment and your dental benefits company underpays or denies a benefit, you are responsible for the remaining balance. Please know that we will do everything possible to see that you receive the full benefits of your policy. By signing you are authorizing the doctor and staff to start dental examination and xrays. Also authorizing your insurance company to pay the Dentist all the insurance benefits otherwise payable to me for service rendered, and authorizing the use of your signature on all insurance submissions and to release all information necessary to secure payments for your services.

PATIENTS ARE RESPONSIBLE FOR THE FULL AMOUNT OF THEIR BILL.

Broken Appointments

Your appointment is time that has been reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 48 hours notice to avoid a $75.00 cancellation fee. If you miss an appointment without notifying our office, you will be required to pay 50% of the value of your next appointment (non-refundable) before scheduling. If you miss more than one scheduled appointment without notifying us, you may be dismissed. We appreciate your understanding of how important keeping appointments are to the doctor and our other patients. **I understand and agree to all of the above office procedures and Financial Policy**

Patient / Legal Guardian Signature: ________________________________ Date:

Date : Patient :

Milliken Dental – Rancho Dental Treatment Consent Form

1. EXAMINATIONS AND X-RAYS
Initial __________ I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan.

2. DRUGS, MEDICATIONS, AND SEDATION
Initial __________ I have been informed and understand that antibiotics and other medications can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

3. CHANGES IN TREATMENT PLAN
Initial __________ 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, the most common being root canal therapy following routine restorative procedures. I give my permission to Dr.Villarroel to make any/all changes and additions as necessary.

4. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)
Initial __________ I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility.

5. FILLINGS
Initial __________ I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I understand that sensitivity is a common after effect of a newly placed filling.

6. REMOVAL OF TEETH
Initial __________ Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize mi Dentist to remove the following teeth and any others 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 (Paresthesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is may responsibility.

7. CROWNS, BRIDGES, CAPS, VENEERS, AND BONDING
Initial __________ 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 that the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation. It has been explained to me that, in a very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures.

8. DENTURES-COMPLETE OR PARTIAL
Initial __________ I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

9. ENDODONTIC TREATMENT (ROOT CANAL)
Initial __________ 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 metal objects are cemented in the tooth or 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).

10. PERIODONTAL TREATMENT
Initial __________ I understand that I have a serious condition causing gum inflammation and/or bone loss, and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery, and/or extractions. I understand the success of any treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, follow a healthy diet, avoid tobacco products and follow other recommendations.

11. DENTAL MATERIALS FACT SHEET
Initial __________ I have received and read a copy of the dental materials fact sheet as required by law.

12. LIPS, TONGUE & SURROUNDING TISSUES
Cuts and Abrasion lesions caused by instruments may occur on lips, tongue and surrounding tissues

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 acknowledge the receipt of and understand post-operative instructions and have been given an appointment date to return.

Patient / Legal Guardian Signature:____ **Date:**

Dental Questionnaire (Date:) Patient :

Reason for today's Visit? : ……………………………………………
………………………………………………
………………………………………………

Check if you have any problems with any of the following:

( ) Difficulties with past dental treatments
( ) Bad Breath
( ) Occasional gum bleeding
( ) Aesthetics of your teeth
( ) Food collection between teeth
( ) Grinding teeth / Clenching
( ) Sensitivity to cold , sweet , heat
( ) Clicking / popping jaw
( ) Difficulty opening or closing jaw
( ) Loose teeth

What would you charge about your smile?

( ) Want whiter teeth
( ) Want straighter teeth
( ) Would change silver fillings to white fillings

Health Questionnaire

MEDICATIONS:

Please list any medication that you are taken or have taking during last year:
………………………………………………………………………
………………………………………………………………………
………………………………………………………………………
………………………………………………………………………
………………………………………………………………………
………………………………………………………………………

ARE YOU ALLERGIC TO?

( ) Aspirin
( ) Penicillin
( ) Iodine
( ) Codeine
( ) Latex
( ) Sulfa
( ) Local Anesthetics - Lidocaine
( ) Other:
……………………………….

Do you have or have you had any of the following conditions or diseases? :

( ) AIDS / HIV	( ) Epilepsy	( ) Rheumatic Fever
( ) Arthritis - Rheumatism	( ) Fen-Phen or Redux use	( ) Shortness of Breath
( ) Artificial Heart Valve	( ) Heart Murmur	( ) Sinus Problems
( ) Artificial Joints	( ) Heart disease	( ) Stroke
( ) Asthma	( ) Hepatitis	( ) Thyroid Problems
( ) Abnormal Bleeding	( ) High Blood Pressure	( ) Tuberculosis
( ) Blood Disease	( ) Liver Disease	( ) Ulcer
( ) Cancer	( ) Mitral Valve Prolapsed	( ) Venereal Disease
( ) Chemical Dependency	( ) Pacemaker	( ) BIOPHOSPHONATES?
( ) Congenital heart problems	( ) Psychiatric Care	( ) are you pregnant?
( ) Chemotherapy	( ) Kidney Disease	( ) Are You Nursing
( ) Diabetes	( ) Radiation Therapy	( ) OTHER NOT LISTED? :
( ) Emphysema	( ) Respiratory Disease	………………………………………

Did you ever have Mental or Psychological problems requiring professional treatment? ( )
Do you have any other medical condition or disease not mentioned above? ( )

HEALTH QUESTIONNAIRE ACKNOWLEDGMENT and CONSENT TO PROCEED

I herby certify that the answers to the foregoing health questions are accurate and correct to the best of my knowledge. Since a change of medical conditions and/or medications can affect dental treatment, I understand the importance of and agree to take the responsibly to notify the dentist of any changes at any subsequent appointment. I authorize Dr. Villarroel and Associates, associates or assistants as she/he may designate to perform those procedure as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments. I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising,hematoma, cardiac stimulation, temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval. I understand that as part of dental treatment, including preventive procedures such as cleanings and basic dentistry, including filling of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, check or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases sutures or additional treatment may be required. I understand that as part of dental treatment items including, but not limited to crown, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases require bronchoscopy or other procedure to ensure safe removal. I understand that need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis may result in complications of non-healing of the jawbones following oral surgery. I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hope of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Signature ____ Date :