REGISTRATION

Date: _____ Patient's Name: _____ Age: _____ DOB: _____

If Child, Parent's Name: _____ E-Mail: _____

Single: _____ Married: _____ Divorced: _____ Widowed: _____ Minor: _____

Residence: _____
Street Apt# City State Zip

Telephone:
Res. _____ Bus. _____ Fax: _____ Cell: _____

Patient/Parent Employed By: _____ Present Position: _____

Spouse/Parent Name: _____

Spouse Employed By: _____ Present Position: _____

Who is responsible for this account: _____ Drivers License No: _____

Method of Payment: Insurance: ____ Cash: ____ Credit Card: _____

Other family members in this practice: _____

Whom may we thank for this referral: _____

Patient/parent Social Security Number: _____

Spouse/parent Social Security Number: _____

In case of emergency (not living with you): _____

Dental Insurance 1st Coverage

Employee Name: _____ Date of Birth: _____

Employer Name: _____ Years: _____

Name of Insurance Company: _____

Telephone: _____ Program/Policy #: _____

Social Security Number: _____ Union Local/Group: _____

Dental Insurance 2nd Coverage

Employee Name: _____ Date of Birth: _____

Employer Name: _____ Years: _____

Name of Insurance Company: _____

Telephone: _____ Program/Policy #: _____

Social Security Number: _____ Union Local/Group: _____

CONSENT FOR DISCLOSURE AND PAYMENT

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

Names: _____

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

Patient or Guardian's Signature: _____

Date: _____

Donna Bautista, D.D.S

26137 La Paz Road, Suite 270
Mission Viejo, CA 92691

FINANCIAL POLICY

For those without insurance we offer the payment options listed below.

For those with insurance, thank you for sharing with us the specifics of your dental benefits. As you may know, dental insurance does not always cover the cost of your treatment. In these instances, you will be responsible for financing your dental treatment. In order to keep our fees to you as low as possible, we ask that you pay your estimated co-payment at the time you receive treatment. It is not always possible for us to verify your benefits – and we are not responsible for verifying your coverage – although we will do as much as possible to aid you in estimating your coverage.

Please understand that all estimates are but a guideline from which to work until payment is received from your insurance company and our exact share is known.

Please check below the method of payment you intend to use for your dental treatment, including your co-payment.

Payment Options:

- ☐ Cash or check
- ☐ Visa, Mastercard, Discover, or American Express

Extended Payment Options:

- ☐ Dental Practice – For Treatment Greater Than $1500
  Your portion can be divided into a maximum of 3 monthly payments beginning with ½ down when treatment is started, and the balance being divided into two equal payments.
- ☐ My own personal financial institution (Obtain a loan from credit union, bank, flex account, etc.)

Missed Appointments:
Unless cancelled at least 24 hours in advance, our policy is to charge $50 for each missed hour of appointment time. Please help us serve you better by keeping scheduled reservations or giving us sufficient notice to enable someone else to use that valuable time.

Consent:
The undersigned hereby authorizes Dr. Bautista to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Bautista to perform any and all forms of treatment and therapy that may be indicated, and to release any pertinent information to my insurance company. I authorize benefits to be paid directly to Dr. Bautista.

I understand that:
Responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered, unless financial arrangements have been made. We reserve the right to add a 10% monthly finance charge to any balances over 90 days past due unless prior arrangements have been made in writing. Reasonable attorney's fees and costs of collection in the event of default may also be added to the final balance. When appropriate, credit bureau reports may be obtained. I assign all insurance benefits to Dr. Bautista.

"I have read, understood, and agree to all of the above and have filled out all information to the best of my knowledge."

Patient or Responsible Party:_____ **Date:**_____

Important Dental Insurance Information For Our Patients

We know understanding your insurance coverage can be quite challenging. Our goal is to assist you in maximizing your benefits. We care for patients from many different companies. Each company pays an insurance premium for specific coverage that fits the company budget. Each plan is slightly different in its covered services. We encourage you to become familiar with your policy exclusions, deductibles and required co-payments.

Our Courtesy Service To You Includes:

1. Filing your insurance within 24 hours of your visit and requesting payment of your benefit to our office.
2. Electronically filing your insurance for short turnaround.
3. Researching your dental insurance plan to advise you of benefits to you.
4. Re-filing your insurance a second time within 60 days.
5. Following the American Dental Association for coding procedures and filing insurance.

Our Expectations Of You As The Owner Of The Policy:

1. Payment of fees not covered by your insurance at the time the service is delivered.
2. Understanding the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
3. Realizing that dental insurance policies restrict payment for some services, use restricted fee schedules (called usual and Customary Rates) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for insurance not our fees or recommended treatment.
4. Taking responsibility for payment if the insurance company does not pay our office within 75 days.
5. Keeping our office informed of any changes in your insurance coverage or employment.

Thank you for your cooperation with your dental insurance coverage. Please sign below and have your insurance card ready for us to copy for our file.

I hereby authorize Dr. Donna Bautista to release to my insurance company, information acquired in the course of my dental care. I authorize benefits to be paid directly to Dr. Donna Bautista. I understand I am responsible for any unpaid balance.

Signed _____ **Date** _____

DENTAL HISTORY

Patient's Name _____
Last First Initial Date of Birth

1. Purpose of initial visit: _____
2. How long since your last dental visit? _____
   - What was done at that time? _____
   - When was the last time your teeth were cleaned? _____
   - Were dental x-rays taken? **Yes or No**

     Previous dentist's name: _____
     Address: _____
     Telephone Number: _____

Please circle the appropriate answer. If you don't know the answer, please write "Don't Know" on the line after the question.

3. Have you made regular dental visits? Yes No
   How often: _____
4. Have you lost any permanent teeth or have any teeth been removed? Yes No
   - Why: _____
   - Have they been replaced? Yes No
   - How have they been replaced? _____

   Fixed bridge: _____ Age: _____
   Removable Bridge: _____ Age: _____
   Denture: _____ Age: _____
   Implant: _____ Age: _____
   Are you unhappy with the replacement? Yes No

5. Have you ever had any problems or complications with previous dental treatment? Yes No

   If yes, explain: _____

Head/Mouth Wellness:

6. Do you clench or grind your teeth? Yes No
7. Does your jaw click or pop? Yes No
8. Have you experienced any pain or soreness in the muscles of your face or around your ear? Yes No
9. Do you have frequent headaches, neck aches or shoulder aches? Yes No
10. Does food get caught in your teeth? Yes No
11. Are any of your teeth sensitive to: Hot: ___ Cold: ___ Sweets: ___ Pressure: ___
12. Do your gums bleed or hurt? Yes No
13. How often do you brush your teeth? ____times a day:( )morning ( ) afternoon ( ) evening

14. How often do you floss your teeth? ____ times a day:( )morning ( ) afternoon ( ) evening

15. Are any of your teeth loose, tipped, shifted, or chipped? Yes No

16. Are you unhappy with the appearance of your teeth? Yes No

17. Do you feel your breath is offensive at times? Yes No

18. Have you ever had gum treatment or surgery? Yes No

What? _____

When? _____

Where? _____

19. Have you had any orthodontic work? Yes No

What? _____

When? _____

Where? _____

20. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? Yes No

What? _____

21. Do you have any questions or concerns? Yes No

If yes: _____

Any Additional Comments:

I certify that the above information is complete and accurate:

Patient's/Guardian's signature: _____ Date: _____

Dentist's signature: _____ Date: _____

CONSENT FOR TREATMENT

Patient Name:_____
First Last Initial Date of Birth

I hereby authorize **DR. DONNA BAUTISTA.** and whomever she may designate as her assistants, to operate or perform dental procedures.

I request and authorize her to do whatever she deems advisable if any unforeseen condition arises in the course of these designated operations and/or procedures calling, in their judgment, for procedures in addition to or different from those now contemplated.

I consent to the schedule treatment after having been advised of the risks, advantages and disadvantages of the treatments and the consequences if this treatment were withheld.

I consent to the scheduled treatment plan after having been advised of the alternate plans of treatment available and the known material risks, advantages and disadvantages of the alternative treatment.

I further consent to the administration of local or general anesthesia, antibiotics, analgesics or any other drugs that may be deemed necessary in my case, and understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. This risk includes adverse drug response (e.g., allergic reactions), cardiac arrest, and aspiration, and thrombophlebitis (e.g. irritation and swelling of vein), pain, discoloration and injury to blood vessels and nerves which may be caused by injections and of any medications or drugs.

I am informed and fully understand that inherent in any type of surgery are certain unavoidable complications. In oral surgery, the most common of these complications include post-operative bleeding, swelling or bruising, discomfort, stiff jaws, loss or loosening of dental restorations. Less common complications can include but are not limited to infection, loss or injury to adjacent teeth and soft tissues, nerve disturbances (e.g. numbness I mouth and lip tissues), jaw fractures, sinus exposure and swallowing or aspiration of teeth and restorations, and small root fragments remaining in the jaw which might require extensive surgery for removal.

I realize that in spite of the possible complications and risks, my contemplated surgery/treatment is necessary and desired by me. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedures.

I have provided accurate and compete medical and personal history as possible including those antibiotics, drugs, medications and foods to which I am allergic. I will follow any and all instructions as explained and directed to me and permit prescribed diagnostic procedures.

I have had the opportunity to ask questions and receive answers to and responsive explanations for, all questions about my medical condition, contemplated and alternative treatment and procedures, and the risk and potential complications of the contemplated and alternative treatment procedures, prior to signing this form.

Patient or Guardian's Signature_____ Date_____
Dentist Signature_____ Date_____
Witness's Signature_____ Date_____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsilitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain In Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Authorization for the Release of Dental Records

California

I hereby authorize _____, DDS to release the information in the dental record of _____ (patient's name) to

_____
(name of dentist, physician, clinic, or patient's representative)

_____
(address)

_____

Any and all information may be released including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below.

_____

_____

This authorization is effective now and will remain in effect until _____ (date). I understand that I may receive a copy of this authorization.

_____ _____
Signature Date

If not signed by the patient please indicate relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

NOTE: This authorization is intended to comply with applicable state laws. It is not intended as a "Consent" or "Authorization" for the use and disclosure of Protected Health Information (PHI) under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or its implementing regulations. The medical provider to whom this authorization is directed should ensure that he or she is in compliance with applicable HIPAA requirements before releasing the requested records.

CAUTION: If you intend to use the requested information for any purpose other than providing medical treatment, 45 CFR Section 164.502 requires that you make reasonable efforts to limit your request for PHI to the minimum necessary to accomplish the intended purpose of the request.

To be valid, an authorization must be clearly separate from other language on a page and executed by a signature which serves no purpose other than to execute the authorization. It can either be handwritten by the person who signs it or in typeface no smaller than 8 point (this is 8 point).

Place a copy in the patient's chart.