PATIENT's NAME ______________________ AGE______ SEX M F DATE OF BIRTH ____________ REFERRING DENTIST____________________
(LAST) (FIRST) (MIDDLE)

HOME PHONE ________________

MAILING ADDRESS______________________________________ SS#______________ CELL PHONE ________________
(STREET) (CITY) (STATE) (ZIP)

EMPLOYER ______________________ OCCUPATION ______________ DRIVER'S LICENSE ______________ BUSINESS PHONE ________________

SPOUSE ______________________ EMPLOYER ______________________________ BUSINESS PHONE ________________

PARTY RESPONSIBLE FOR PAYMENT ______________________________ RELATIONSHIP TO PATIENT ______________ PHONE ________________

DENTAL INSURANCE ______________________________ POLICY/GROUP# ____________________

CONFIDENTIAL MEDICAL-DENTAL HISTORY

What dental problem caused you to seek treatment at this office? Explain ______________________________

____

Medical Physician ______________________________ Phone No. ______________

Date of last physical exam ______________ Are you now or have you recently been under a physician's care? __________

Reason ____

Have you recently been a patient in a hospital or had any serious illness? ______________________________

Circle any of the following which you have had or suspected:

Arthritis
Rheumatic Fever
Heart Trouble
Heart Attack
Heart Murmur
Mitral Valve Prolapse
High or Low Blood Pressure
Chest Pain
Stroke
Shortness of Breath
Sinus Trouble or Hay Fever

Asthma
Diabetes
Kidney or Bladder Trouble
Anemia
Lung Disease
Blood Disease
Liver Disease
Slow Healing
Prolonged Bleeding
Ulcers, Stomach Problems
Hepatitis or Jaundice

Hip/Knee, Joint Replacement
Severe Infections
Severe Headaches
Fainting Tendency
Epilepsy
Thyroid Disease
Glaucoma
Radiation Therapy or Cancer
Venereal Disease
AIDS/HIV
Others NOT LISTED ______________

NOTES ____

____

Circle any of the following drugs you are taking or have taken on a regular basis.

Cortisone drugs
Steroids
Aspirin

Osteoporosis Medication (Bisphosphonates)
Blood Thinners
Diet Pills/Fen-Phen

Heart Medication
Sedatives
Others ______________________

Please list medications you are currently taking. ______________________________

NOTES ____

____

Are you **Allergic** to or suffer ill effects from? (circle if applicable)

Penicillin
Aspirin
Other______________________

Codeine
Sedatives
Erythromycin

SULFA
Dental/Local Anesthetics/Epinephrine
Latex Products/gloves

Any past problems with Dental Treatment? ______________________________

Women only: Are you pregnant (Possibly)?______________________ How many months? ______________

Are you breast feeding your child? ______________________ OB/Gyn ______________

Are you presently taking any medicine of any kind routinely? (Birth Control Pills, Hormones, etc.) ______________

Person to contact for emergency ______________________________ Phone ______________

The above is true to the best of my knowledge.

Signature of Patient ______________________________ Date ______________

Reviewed by Doctor______________________________ Date ______________

Reviewed by Doctor______________________________ Date ______________

Dear Friends,

We want to thank you for giving us the opportunity to serve you, the most important part of our practice. The primary goal of our highly trained staff is to provide you with the very best oral health care. We are proud of the fact that we use the most current and state of the art techniques in a friendly, professional and efficient manner to support you in your treatment. Your well being is of the utmost importance to us.

We understand that you may have questions regarding your financial obligations. We want to make certain that you have a complete understanding of our financial policy. Please review the following:

1. **CASH PATIENTS**: 100% of the fees are due and payable at the time services are rendered.

2. **INSURED PATIENTS**: We have made every effort to contact your insurance company prior to your initial visit and get an ESTIMATED benefit summary. We have calculated your ESTIMATED co-payment which is due at the time services are rendered. Please be advised that we are **not** providers for any insurance company except Delta Dental.
   Any balance remaining after your insurance has paid will be billed to you and payable upon receipt. We will bill your insurance as a courtesy to you. If we have not received payment within 60 days, you are responsible for the payment in full, within 10 days of mailing the statement. Please be advised that we do not accept Medicare or Medical Insurance.
   General Anesthesia/IV Sedation is provided by an outside Anesthesiologist and 100% of the fees are due at the time services are rendered. You may bill your Medical/Dental insurance with the information provided to you by the Anesthesiologist.

We want to thank you for allowing us to serve you. If you have any questions, please feel free to ask.

Rancho Endodontic Associates, INC.

Eric A. Pettersen, DDS
And Staff

I have read and understand the above written policy.

Signed____________________________________Date____________

RANCHO ENDODONTIC ASSOCIATES, INC.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ______________________________

Address: ______________________________

Telephone: ______________________ E-mail: ______________________

Patient Number: ______________________ Social Security Number: ______________________

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Sophia Anderson, Office Manager

Telephone: 909-677-7322 Fax: 909-677-1860

Address: **25460 Medical Center Dr. #200, Murrieta, CA 92562**

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Print Name

I, ______________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: ______________________ Date: ______________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ______________________________

Relationship to Patient: ______________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

ENDODONTIC CONSENT AND INFORMATION FORM

Root Canal Therapy, Endodontic surgery, Anesthetics and Medications

We would like our patients to be informed about the various procedures involved in endodontic therapy and have their consent before starting treatment. Endodontic (root canal) therapy is performed in order to save a tooth which otherwise might need to be removed. This is accomplished by conservative root canal therapy, or when needed, endodontic surgery. The following discusses possible risks that may occur from endodontic treatment, and other treatment choices.

RISKS: Included (but not limited to) are complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics and injections. These complications include: swelling, sensitivity, bleeding, pain, infection; numbness and tingling sensation in the lip, tongue, gums, cheeks and teeth, which is transient but on infrequent occasions may be permanent; reaction to injections; changes in occlusion (biting); jaw muscle cramps and spasms; temporomandibular (jaw) joint difficulty; loosening of teeth; referred pain to ear, neck and head; nausea, vomiting, allergic reactions, delayed healing, sinus perforations and treatment failure.

RISKS MORE SPECIFIC TO ENDODONTIC THERAPY: The risks include the possibility of instruments broken within the root canals; perforation (extra openings) of the crown or root of the tooth; damage to bridges, existing fillings, crowns or porcelain veneers, loss of tooth structure in gaining access to canals, and cracked teeth. During treatment, complications may be discovered which make treatment impossible, or which may require dental surgery. These complications may include: blocked canals due to fillings or prior treatment, natural calcifications, broken instruments; curved roots, periodontal disease (gum disease), splits or fractures of the teeth.

MEDICATIONS: Prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers, sedatives or other drugs). It is not advisable to operate any vehicle or hazardous device until recovered from their effects.

OTHER TREATMENT CHOICES: These include no treatment, waiting for more definite development of symptoms, tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth, and infection to other areas.

CONSENT: I, the undersigned, being the patient (parent or guardian of above minor patient) consent to the performing of procedures decided upon to be necessary or advisable in the opinion of the doctor. I also understand that upon completion of root canal therapy in this office, I shall return to my general family dentist for a permanent restoration of the tooth involved, such as a crown, cap, jacket, onlay or silver filling.

I understand that root canal treatment is an attempt to save a tooth which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth which has had root canal therapy may require retreatment, surgery or even extraction.

______________	______________________________	______________________
Date	Patient/Parent Signature	Witness