Dental Dynamic Services Inc. DBA Agape Dental
5752 Lonetree Blvd.
Rocklin, CA 95765

(916) 824-8711

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient # ____________________

Date ____________________

PATIENT INFORMATION

Name ____________________ Birthdate ____________ SS# ____________

Address ____________________ City ____________ State ________ Zip ________

Sex ☐M ☐F ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Home Phone # (   ) ____________ Cell Phone #1 (   ) ____________ Email ____________

Employer ____________________ Employer Phone (   ) ____________

Employer Address ____________________ City ____________ State ________ Zip ________

Spouse or Parent's Name ____________________ Employer ____________ Work Phone (   ) ____________

Whom may we thank for referring you? ____________________

Person to contact in case of emergency ____________________ Phone (   ) ____________

RESPONSIBLE PARTY

Name of Person Responsible for this Account ____________________ Relation to Patient ____________

Address ____________________ Home Phone (   ) ____________

Birthdate ____________________ Currently a patient in our office? ☐Yes ☐No

Employer ____________________ Work Phone (   ) ____________

E-Mail ____________________ Cell Phone (   ) ____________

DENTAL INSURANCE INFORMATION

Name of Insured ____________________ Relation to Patient ____________

Birthdate ____________ Social Security # ____________ Date Employed ____________

Employer ____________________ Work Phone # (   ) ____________

Employer Address ____________________ City ____________ State ________ Zip ________

Insurance Company ____________ Group # ____________ Union or Local # ____________

Additional Insurance ____________________ ____________

Insurance Name ____________ Group Number ____________

PRACTICE POLICIES

Co-pays are due at time of treatment unless prior arrangements were made. Pt. Initial ________

Surcharge fees will be assessed for third party payors ex. CareCredit. Pt. Initial ________

A $50 fee will be charge for last minute cancellations (no 48 hr. notice) or no shows. Pt. Initial ________

We have the right to refuse service to anyone exhibiting unacceptable behaviour. Pt. Initial ________

DENTAL HISTORY

Reason for today's visit ______________________ Date of last dental care ______________________

Former Dentist ______________________ Date of last dental X-rays ______________________

Address ____

Check (✓) if you have or have had problems with any of the following:

Y☐N☐ Bad Breath	Y☐N☐ Grinding Teeth	Y☐N☐ Sensitivity to hot
Y☐N☐ Bleeding Gums	Y☐N☐ Loose teeth or broken fillings	Y☐N☐ Sensitivity to sweets
Y☐N☐ Clicking or popping jaw	Y☐N☐ Periodontal treatment	Y☐N☐ Sensitivity when biting
Y☐N☐ Food collecting between the teeth	Y☐N☐ Sensitivity to cold	Y☐N☐ Sores or growths in your mouth

How often do you floss? ______________________ How often do you brush? ______________________

What is the reason of your dental visit today? ______________________ Have you ever had orthodontic(braces) treatment? ______________

Do you participate in active sports or activities? ______________________ Have you ever had a serious injury to your head or mouth? ____________

How do you feel about your smile? ______________________

MEDICAL HISTORY

Physician's Name ______________________ Date of last visit ______________________

Would you be interested in doing Oral Cancer Screening Today? ($50 fee) ☐Yes ☐No

Have you ever taken bone loss prevention drugs such as Fosamax, Actonel,Boniva or other similar drugs? ☐Yes ☐No

Since 2001, were you treated or scheduled with IV Biphosphonates (Aredia or Zometa) for bone pain,hypercalcemia or any skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐Yes ☐No

Have you ever had any serious illnesses or operations?? ☐Yes ☐No If yes, describe ______________________

Have you ever had a blood transfusion? ☐Yes ☐No If yes, give approximate dates ______________________

(Women) Are you pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No Taking birth control pills? ☐Yes ☐No

Check (✓) if you have or have had problems with any of the following:

Y☐N☐Anemia	Y☐N☐Congenital Heart lesions	Y☐N☐Hepititis	Y☐N☐Scarlet Fever
Y☐N☐Arthritis, Rheumatism	Y☐N☐Cortisone Treatments	Y☐N☐Hernia Repair	Y☐N☐Shortness of Breath
Y☐N☐Artificial Heart Valves	Y☐N☐Cough, Persistent	Y☐N☐High Blood Pressure	Y☐N☐Skin Rash
Y☐N☐Artificial Joints, Pins, etc.	Y☐N☐Cough up Blood	Y☐N☐HIV/AIDS	Y☐N☐Stroke
Y☐N☐Asthma	Y☐N☐Diabetes	Y☐N☐Jaw Pain	Y☐N☐Swelling of Feet or Ankle
Y☐N☐Back Problems	Y☐N☐Epilepsy	Y☐N☐Kidney Disease	Y☐N☐Thyroid Problems
Y☐N☐Bleeding Abnormally	Y☐N☐Fainting	Y☐N☐Liver Disease	Y☐N☐Tobacco Habit
Y☐N☐Blood Disease	Y☐N☐Glaucoma	Y☐N☐Mitral Valve Prolapse	Y☐N☐Tonsillitis
Y☐N☐Cancer	Y☐N☐Headaches	Y☐N☐Pacemaker	Y☐N☐Tuberculosis
Y☐N☐Chemical Dependency	Y☐N☐Heart Murmur	Y☐N☐Radiation Treatment	Y☐N☐Ulcer
Y☐N☐Chemotherapy	Y☐N☐Heart Problems	Y☐N☐Respiratory Disease	Y☐N☐Venereal Disease
Y☐N☐Circulatory Problems	Y☐N☐Hemophilia	Y☐N☐Rheumatic fever	

List medications you are currently taking:

______________________ ______________________

Allergies:

☐ Aspirin	☐ Local Anesthetic	☐ Iodine	☐ Other ____________
☐ Barbiturates (Sleeping Pills)	☐ Penicillin	☐ Latex	____________
☐ Codeine	☐ Sulfa	☐ None	

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my mindor child, ever have a change in health.

______________________ ____________

Signature of of Patient, Parent, Guardian or Personal Representative — Date

______________________ ____________

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

DR. MIGNON MAPANAO, DMD

GENERAL DENTISTRY INFORMED CONSENT

OFFICE / PATIENT # ____________________ NAME: ____

1. **TREATMENT TO BE DONE:**

   I understand that I will be receiving an examination that includes a sufficient number of dental x-rays that may be necessary to complete my examination and any additional community appropriate diagnostic procedures that may be necessary to complete my dental examination and treatment plan. I also understand that if there was a need for a referral to a specialist deemed necessary by my Dentist, then the cost of this referral would be my responsibility.

   Initials ______

2. **DRUGS AND MEDICATIONS:**

   I understand that antibiotics, analgesics and other medication can cause allergic reactions manifesting clinical symptoms such as redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock severe allergic reaction). I understand that it is my responsibility to inform my dentist of any allergy to specific medication to avoid possible adverse effects from medication that my dentist will prescribe.

   Initials ______

   LOCAL ANESTHETICS: The local anesthetic I am receiving may contain epinephrine that can cause a slight increase in the heart rate but will return to normal. Common complications that can occur from local anesthetic but are not limited to are pain, swelling, and bruising. Rare serious complications may occur that can include but are not limited to permanent numbness, abnormal sensation, transient blindness, and even death.

   Initials ______

3. **CHANGES IN TREATMENT PLAN:**

   I understand that during treatment, it may be necessary to change or add procedures due to condition 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 the Dentist to make any/all changes and additions as necessary once I have been informed of these changes and consented to them. I also understand that by not following my dentist's recommendation, delayed treatment can lead to but not limited to more discomfort, increase the complexity of the treatment outcome, or eventual loss of teeth.

   Initials ______

4. **EXTRACTIONS (REMOVAL OF TEETH):**

   I give my consent for the doctor to perform the extraction/surgery to treat and possibly correct my diseased oral tissue, or other procedures deemed necessary or advisable as necessary to complete the planned operation/extraction. If left untreated, the risks to my health may include, but are not limited to swelling, pain, infection, cyst formation, gum diseases, dental decay, malocclusion, premature loss of teeth and/or bone. My Dentist has informed me of possible alternative methods

   Tooth # _______
   Teeth # _______
   Initials _______

of treatment.

Potential risks include, but are not limited to the following:

A. Post-operative discomfort; stretching of the corners of the mouth, with resultant cracking and bruising; swelling; prolonged bleeding; tooth sensitivity to hot or cold; gum shrinkage possibly exposing crown margins); tooth looseness; delayed healing dry socket) and/or infection requiring prescriptions or additional treatment, i.e. surgery).
B. Injury to adjacent teeth, prosthesis, and/or restorations which may require additional treatment or injury to other tissues not within the described surgical area.
C. Limitation of opening; stiffness of facial and/or neck muscles; change in bite or tempromandibular joint jaw joint) difficulty possibly requiring physical therapy or surgery).
D. Residual root fragments or bones spicules left when complete removal would require extensive surgery or needless surgical complications.
E. Possible bone, and/or jaw fracture, or opening of the maxillary sinus requiring additional surgery.
F. Injury to the nerve underlying the teeth resulting in itching, numbness, or burning of the lip, chin, gums, cheek, teeth, and/or tongue which may be temporary or permanent.

If any unforeseen condition should arise in the course of the operation/extraction, calling for the doctor's judgment or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever s)he may deem advisable, including referral to another dentist or specialist.

5. **CROWNS, BRIDGES, AND CAPS:**

I understand 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 could be aspirated, and I must be careful to ensure that they are kept on until the permanent crowns are delivered. I understand that if my temporary crowns come off, then it is my responsibility to return to my dentist to have it re-cemented. I realize the final opportunity to make changes in my new crown, bridge, or cap including shape, fit, size, and color) will be before cementation. I understand if I do not return for my scheduled appointment for delivery of my crowns, or bridge, it may not fit properly, and I will be responsible for any lab fees.

Tooth # ______
Shade ______
Initials ______

6. **DENTURES - COMPLETE OR PARTIAL:**

I realize full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these 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 most dentures require relining approximately three to six months after initial placement and yearly thereafter. The cost for these relines is not included in the initial denture fee. I further understand that due to bone loss, lack of alveolar ridge support, muscle attachments and/or other complicating factors, I may never be able to wear dentures to my satisfaction.

Shade ______
Initials ______

7. **ENDODONTIC TREATMENT (ROOT CANAL):**

The purpose and method of root canal therapy have been explained to me as well as consequences of non-treatment and reasonable alternative treatments. I understand that following root canal therapy my tooth will be brittle and must be protected against fracture by placement of a final restoration usually a crown cap) over the tooth. I also understand that

Tooth # ______
Initials ______

sometimes root canal therapy may fail and further treatment may be necessary that might include but not limited to retreatment, apicoectomy, or extraction.

I understand that treatment risks can include, but are not limited to the following:

A. Post treatment discomfort, infection, restricted jaw opening.
B. Swelling of the gum area in the vicinity of the treated tooth or facial swelling, either of which may persist for several days or longer.
C. Separation of root canal instruments during treatment, which may in the judgment of the Dentist be left in the treated root canal or bone as part of the filling material; or it may require surgery for removal.
D. Perforation of the root canal which may require additional surgical treatment, or premature tooth loss extraction).
E. Risk of temporary or permanent numbness in treatment vicinity.
F. The root canal filling material may be overfilled or under-filled, which may or may not affect the success/outcome of the treatment

8. **PERIODONTAL (LOSS OF TISSUE & BONE):**

I understand that the long term success of treatment and status of my oral condition depends on my efforts at proper oral hygiene (i.e. brushing and flossing) and maintaining regular recall and maintenance visits. I understand that I have a serious condition causing gum and bone inflammation and/or loss that can lead to loss of my teeth and other related systemic complications. The various treatment plans have been explained to me, including non-surgical scaling and root planning followed by local irrigation with oral medicaments and local delivery of antibiotic, or gum surgery, or replacements and/or extractions. I also understand that although these treatments have a high degree of success, they cannot be guaranteed. I understand that after following approved periodontal treatment there may still be a need for a referral to a Periodontist.

Initials ______

9. FILLINGS:

I have been advised of the need for fillings, either silver or composite plastic). In cases where very little tooth structure remains or existing tooth structure fractures off, I may need to receive more extensive treatment such as root canal therapy, post and build-up, and crowns), which would necessitate a separate charge. I understand that my recently placed fillings may cause some sensitivity and discomfort for duration and may be alleviated with time. However, I understand that if the symptom and sensitivity worsen, then I might need a RCT.

Initials ______

10. PEDODONTICS (CHILDREN'S DENTRISTY):

I understand the following procedures are routinely used in conjunction with pediatric dentistry, as well as being accepted procedures in the dental profession. As the parent or authorized caregiver, I understand and give consent that the following procedures can be used on my child:

A. POSITIVE REINFORCEMENT - Rewarding the child who portrays desirable behavior, by use of compliments, verbal praises, or toys.
B. VOICE CONTROL - The attention of a disruptive child is gained by changing the tone or increasing the volume of the doctor's voice.
C. PHYSICAL RESTRAINT- As the parent or authorized caregiver, I have been informed in advance and have given consent as it may be deemed necessary to restrain the child. Restraining the child's disruptive movements by holding down their hands, upper body, head, and/or legs by use of the dentist's or assistant's hand or arm.

Initials ______

I understand that with the use of local anesthetic for dental purposes, the possibility exists that the child may inadvertently bite their lip, tongue, and cheek causing injury to occur.

I understand that dentistry is not an exact science and that therefore, practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding dental treatment which I have requested and authorized. I have read and clearly understood the consent form language, and by signing below I acknowledge this understanding and give my consent to SmileCare to perform the above- indicated procedure[s]. My SmileCare doctor has encouraged me to ask questions. I have had the opportunity to ask question and any and all of my questions have been answered to my satisfaction.

Signature: ____ Date: _________________________

Doctor: ____ Witness:_______________________

Patient Acknowledgements and Authorizations

Patient Acknowledgements: HIPPA requires health care providers that are covered entities to obtain a patient's acknowledgement of receipt of providers Notice of Privacy Practices. The Dental board of California requires a dental practice to obtain a patients acknowledgements of receipt of Dental Materials Fact sheet prior to the performance of a restorative procedure. A patient can refuse to sign either acknowledgement. A provider cannot refuse treatment based on a patient's refusal to sign either acknowledgement.

Patient Responsibilities We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.
Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment: <u>Cash, Credit, Care Credit, Debit</u> *Note: if you elect to apply for third party financing, administered through our practice, we are required by law to provide you with a Credit for Dental Services Notice.
Dental Benefits Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage. Our practice IS/ IS NOT (circle one) a contracted provider with your dental benefit plan.

-If we are a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.

-If we are not a contracted provider with your dental benefit plan, it is the patient's responsibility to verify the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services form out of network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you assign benefits to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than out estimated patient portion of the bill. If you choose not to assign benefits to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at time of service.

Scheduling of Appointments: When a patient cancels and appointment, it affects the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 48 hr notice to reschedule an appt. With less than 48 hour notice, a fee of $50 or deposit to reserve the appointment time again may be required. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is 15 minutes late or more arriving to our practice. To reschedule an appointment due to late arrival, a fee of $50 or deposit to reserve the appointment time again may be required.

Patient Authorizations
I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during the diagnosis and treatment.________(initial)

I have read the above and agree to the financial and scheduling terms. _____(initial)

Patient communication

Messages: I understand brief messages from the dental practice may be left on my home answering machine or with anyone who answers the telephone at my home unless I have provided the practice alternate instructions for communication. _____(initial)

Email: Except for appointment reminders, we use secure methods to electronically communicate with our patients. Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive of confidential information that may be contained in such email may ne misdirected, disclosed to or intercepted by unauthorized third parties. However you may consent to receive unsecured email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify your email address.

- o I consent and accept the risk of receiving information via unsecured email. I understand I can withdraw my consent at any time. My email address is _________________________________

- o I consent to receiving appointment reminders only via unsecured email. I understand I can request an alternate method of appointment reminders at any time ________(initial)

- o I do not consent to receiving and information via email. I understand that I can change my mind and provide consent later. ______(initial)

Cell Phone:

- o I consent to the dental practice using my cell phone number to call or text regarding appointments and to call regarding treatment, insurance and my account. I understand that I can withdraw my consent at any time. My cell phone number is ___________________________(initial)

Patient Acknowledgements: I hereby acknowledge that a copy of this practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this notice.____(initial)

I hereby acknowledge that a copy of this practice's Dental Materials Fact sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet.___(initial)