PERSONAL INFORMATION

First Name: _____ Last Name: _____ M.I.: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Email: _____

Nickname: _____ ☐ Male ☐ Female Date of Birth: _____ Age: _____

Address: _____ Apt.# _____ City _____ State: _____ Zip: _____

Home Phone: _____Work: _____Cell: _____

Employer: _____ Occupation: _____

If child or student, parent or guardian name: _____

How did you hear about our office? _____

Spouse name: _____ DOB: _____

Spouse's employer: _____Occupation: _____

2nd Insurance: ☐ Yes ☐ No Name of Insurance Company: _____

In case of emergency, please call: _____ Tel. #:_____

ACCOUNT INFORMATION/POLICY HOLDER: ☐ Check if POLICY HOLDER information is same as above

Person financially responsible for account: _____

Address of account holder, if different from above: _____

Are you covered by a dental plan? ☐ Y ☐ N Name of Plan:_____ Group #: _____

Who is the subscriber to the plan? Name: _____

SS# _____ DOB: _____ Driver's License # _____

PLEASE READ AND INITIAL EACH LINE

_____ I acknowledge receipt of the current Dental Materials Fact sheet.

_____ I acknowledge receipt of office privacy practices as required by the HIPAA.

_____ I have been informed and I am aware that I will be charged a $75.00 fee if I fail to cancel or/ reschedule my appointment 48 hours in advance.

AUTHORIZATION AND RELEASE

I authorize the dentist to release any information including the diagnosis and the record of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners.

Signature:_____ **Date:** _____

DENTAL INSURANCE HOLDERS ONLY:

My dentist may give my carrier, or any other carrier, information about my dental condition or treatment, needed to determine benefits." I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less that the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature:_____ **Date:** _____

Maria C. Galdiano, DMD., INC

Name: _____

PATIENT HEALTH HISTORY

Date of last Medical Exam: _____

How would you describe your health? ☐Excellent ☐Very Good ☐Good ☐Fair ☐Others: Please describe?_____

Do you have a Medical Physician? ☐No ☐Yes: Name of Physician_____ Tel. #_____

1. Are you now or have you been under the care of a physician within the past five years? ☐Yes ☐No: Why?_____
2. Have you had any major surgery or hospitalization? ☐No ☐Yes. Describe: _____When: _____
3. Are you now or have you recently been taking any medication? If so, for what?

_____

_____

_____

_____

4. What is the name of your pharmacy? _____ Address: _____
5. Are you taking or have you ever taken Bisphosphonates for osteoporosis, multiple myeloma, or other cancers?

   ☐No ☐Yes. (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa)
6. Are you allergic to or have any reactions to any of the following:

	Y	N		Y	N		Y	N
Local Anesthetics (e.g. Novocain)			Aspirin			Iodine		
Penicillin or any other antibiotics			Codeine			Latex rubber		
Sulfa drugs			Barbiturates			Others (please list)		
Any metals (e.g. nickel, mercury)			Sedatives					

7. **WOMEN ONLY:**

	Y	N
Are you pregnant or think you may be pregnant?		
Are you nursing?		
Are you practicing birth control medication?		

8. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

	Y	N		Y	N		Y	N		Y	N
Heart Attack			Joint Replacement/Implant			Cancer			Gonorrhea		
Heart Failure			Kidney Trouble			Glaucoma			Cold Sores		
Heart Surgery			Congenital Heart Defect			Arthritis			Genital Herpes		
Heart Disease			Pain in Jaw Joints			Emphysema			Fainting/Dizzy Spells		
Angina Pectoris			Aids or HIV Infection			Liver Disease			Nervousness		
Heart Murmur			Hepatitis A (infectious)			Tuberculosis			Psychiatric Treatment		
High Blood Pressure			Hepatitis B (serum)			Asthma			Sickle Cell Disease		
Rheumatic Fever			Hepatitis C			Diabetes			Bleeding Gums		
Ulcers			Sinus Trouble			Yellow Jaundice			Tooth Pain		
Scarlet Fever			Hay Fever/Allergies			Blood Transfusion			Bad Breath		
Artificial Heart Valve			Thyroid Disease			Drug Addiction			Chronic Headaches		
Mitral valve Prolapse			Radiation Therapy			Hemophilia			Chronic Neck Aches		
Heart Pacemaker			Chemotherapy			Syphilis			Cosmetic Surgery		
Stroke			Epilepsy or Seizures			Leukemia			Cortisone Medicine		
Others not listed:											

PATIENT DENTAL HISTORY

	Y	N		Y	N
1. Do your gums bleed while brushing or flossing?			**8. Do you have frequent headaches?**		
2. Are your teeth sensitive to hot or cold liquids/foods?			**9. Do you clench or grind your teeth?**		
3. Are your teeth sensitive to sweet or sour liquids/foods?			**10. Do you bite your lips or cheeks frequently?**		
4. Do you feel pain in any of your teeth?			**11. Have you ever had any difficulty with extractions in the past?**		
5. Do you have any sores or lumps in or near your mouth?			**12. Have you ever had any orthodontic treatment?**		
6. Have you had any head, neck, or jaw injuries?			**13. Have you ever had any prolonged bleeding following extractions?**		
7. Have you ever experienced: Clicking, Pain (joint, ear, side of face), Difficulty in opening or closing, Difficulty in chewing?			**14. Do you wear dentures or partials? If yes, date of placement:**		
			15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?		
			16. Do you like your smile?		

Authorization and Release

I certify that I have read and understood 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. I authorize the dentist to release any information including the diagnosis and the records of any treatment rendered to me or my child during the period of such dental care to third party payers and/or health practitioners.

Signature of Patient/Parent or Guardian: _____ Date: _____

Doctor's Signature: _____ Date: _____

This questionnaire was developed based upon the published findings of the **American Academy of Sleep Medicine (AASM)**. The purpose of this questionnaire is to aid qualified medical professionals in identifying possible symptoms of a sleep disorder and is not meant to be used as a substitute for any diagnostic procedure.

Sleep Apnea Questionnaire

Yes/No	Score	Question
Y / N	8	Have you ever been told you stop breathing while asleep?
Y / N	6	Have you ever fallen asleep or nodded off while driving?
Y / N	6	Have you ever woken up suddenly with shortness of breath, gasping, or with your heart racing?
Y / N	4	Do you feel excessively sleepy during the day?
Y / N	4	Do you snore or have you ever been told that you snore?
Y / N	2	Have you had weight gain and found it difficult to lose?
Y / N	2	Have you taken medication for, or been diagnosed with high blood pressure?
Y / N	3	Do you kick or jerk your legs while sleeping?
Y / N	3	Do you feel burning, tingling, or crawling sensations in your legs when you wake up?
Y / N	3	Do you wake up with headaches during the night or in the morning?
Y / N	4	Do you have trouble falling asleep?
Y / N	4	Do you have trouble staying asleep once you fall asleep?
		Total Score

FOR CLINICAL USE ONLY

Low	Moderate	High	Severe
0-7	8-11	12-15	16

Visual Indications

☐ Enlarged/Scalloped Tongue ☐ Retruded Lower Jaw ☐ High Arching Hard Palate
☐ Bruxism ☐ Gastroesophageal Reflux ☐ Enlarged Tonsils ☐ Mouth Breather

Notes:

MARIA C. GALDIANO DMD, INC.

3825 Mission Avenue, Suite D5, Oceanside, CA 92058

Welcome to our office. Our office is dedicated to providing the highest quality dental care in a warm and friendly environment. We strive to treat you with the dignity and respect you deserve while providing courteous, dependable service. We do our best to recognize your personal needs and work to earn your trust.

FINANCIAL POLICY

…Payment for today's visit and your future visits is due at the time of treatment. We are sensitive to the fact that some people may not be able to pay cash for their treatment, therefore we offer several alternative payment programs for your assistance and convenience. These are:

CASH/CHECK DEBIT CARD/CREDIT CARDS EXTERNAL FINANCING ZELLE

There is a 3.0% surcharge applied on all credit card transactions. There is no surcharge applied on debit card transactions.

…Monthly Payment Plans (External Financing): These are separate lines of credit card that do not affect the balances of your other credit cards. Unlike other credit cards there are no annual fees, monthly payments may be as low as 3% of the understanding balance. Completion and approval of proper credit application is required. You can choose from our five external financing options: **Alphaeon Credit, Cherry Financing, Care Credit, and Sunbit Financing.**

FOR INSURANCE CARRIERS

…As a courtesy, we will send your insurance claims for payment; any co-payment by the insured will be due upon treatment. Assignment of Benefits will have to be rendered to the office. **In some instances, insurance companies may send payment directly to you or the subscriber, payment for services rendered need to be forwarded to Dr. Maria Galdiano with the statement of treatment to properly settle your account.** (Please sign other forms for assignment of benefits.)

RECORDS/ X-RAY DUPLICATION

…All original x-rays taken in conjunction with diagnosis and treatment are the legal property of our office. Request for a copy requires your signature. Printed copies may be picked up or mailed to you after 5 working days.

APPOINTMENT CANCELLATION

…We respect and value your time. Forty-eight hour notice is required for cancellation or to reschedule an appointment. This will allow us to offer the void time to other patients needing treatment. **Your account will be charged a fee of $75.00 per hour for "No Show," cancellation and/or rescheduling an appointment less than the requested 48 hours' notice.**

_____ _____

As the responsible party, my signature acknowledges that I have read and understood fully the information above.

Date

Consent for Use and Disclosure of Health Information

Section A: Patient Giving Consent

Name: _____ Address: _____

Section B: To the Patient — Please Read 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 the office manager. Phone:

Right to Revoke: You will have the right to revoke this Consent at any time by giving us a 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 receive your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

Signature

I, _____, have had the 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 health care operations.

Signature (patient/parent/guardian): _____ Date: _____

Section C: Additional People to have access to information

I would like to give the following persons access to personal health information. (ex. spouse or family)

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation:_____

Signature (patient/parent/guardian): _____ Date: _____

Oral Cancer Screening Acceptance Form

Complete each time the examination is performed and place in the patient's file

Our practice continually strives to provide important enhancements in oral health care for our patients. We are concerned about oral cancer and look for it in all at risk patients.

One person dies every hour from oral cancer in the United States.

Late detection of oral cancer is the primary reason that mortality rates are so dismal. As with most other cancers, age is the primary risk factor for oral cancer. Though tobacco use is a major predisposing risk factor, **25% of oral cancer victims have no lifestyle risk factors**

Oral Cancer Risk Profile

Increased risk

- Patients age 40 and older (95% of all cases)
- 18-39 yeast of age combine with any of the following:
    - Tobacco use
    - Chronic alcohol consumption
    - Oral HPV infection

Highest Risk

- Patients age 65 and older with lifestyle risk factors
- Patients with history of oral cancer

25% of oral cancers occur in people who don't smoke and have no other risk factors.

We find that using Velscope along with a visual oral cancer examination improves our ability to identify suspicious areas that may have been missed during the conventional examination. Early detection of precancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. Velscope is a painless exam that gives us a better chance to find any oral abnormalities you may have at an early stage.

Dental insurance might not cover the Velscope exam. The fee for this enhanced examination is **$25**.

Yes. I authorize the clinician to perform the Velscope exam along with the standard oral cancer examination. I accept financial responsibility for this enhanced examination.

Print name: _____

Signature: _____ Date: _____

No. I would prefer not to have the Velscope exam at this time. I am aware of the consequences if Velscope examination is not performed.

Print name: _____

Signature: _____ Date: _____

CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct the dentist of GALDIANO DENTISTRY AND ASSOCIATES and/or dental auxiliaries of his/her choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.
    a. Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.
    b. Application of plastic "sealants" to the grooves of the teeth.
    c. Treatment of diseased to injured teeth with dental restorations (fillings and crowns).
    d. Replacement of missing teeth with dental prostheses (bridges, partial dentures, full dentures).
    e. Removal (extraction) of one or more teeth.
    f. Treatment of diseased or injured oral tissues (hard and/or soft).
    g. Use of sedative drugs to control apprehension and/or disruptive behavior.
    h. Treatment of malposed (crooked) teeth and/or oral developmental growth abnormalities.
    i. Use of general anesthesia to accomplish the necessary treatment.
2. I understand that there are risks involved in this treatment and hereby acknowledge that these risks will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.
3. I will be advised that the success of the dental treatment to be provided will require that the patient and/or parents of the patients follow post-operative and post-care instructions of the dentist(s). I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his/her auxiliaries must be maintained.
4. I recognize that during the course of treatment, unforeseen circumstances may necessitate additional or different procedures from those discussed. I, therefore, authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being, in the professional judgment of the dentist.
5. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip or cheek biting resulting in ulceration and infection of the mucosa. I, also, understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function), and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.
6. I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctor. Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose pieces leave an indentation or ring around the nose which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.
7. I, also, authorize the doctors to use photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications.
8. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.
9. I further understand that this consent will remain in effect until such time that I choose to terminate it.

Date: _____ Time: _____ AM/PM

Patient's Name _____ Name of Parent or Guardian: _____
Relationship to Patient: _____

_____
Signature: Patient or Parent or Guardian Witness _____

Getting To Know You

Name: _____ **Date:** _____

"Our promise is to provide you the opportunity for a dental experience that meets or exceeds your expectations in a caring, comfortable, and professional atmosphere. We will provide you preventive care to enhance your smile, improve and maintain your dental function, and help prevent future dental problems." ***To help us serve your dental needs best, we would like to know more about you. Please take a moment to complete the following questionnaire:***

How did you find out about our office?_____

Date and reason for most recent dental visit: _____

Last professional cleaning: _____ Last full mouth set of x-rays: _____

Previous Dentist (name/location): _____

How often do you usually see your dentist for routine care? _____

How often do you brush your teeth? _____ Floss? _____ Use other cleaning aids (type and frequency)? _____

What do you expect from your visit today? _____

_____

What is most important to you about your dental health? _____

_____

Please complete this sentence: "If I could wave a magic wand and change anything about my teeth or smile, I would _____."

What do you know about periodontal disease? _____

What do you know about the connection between oral health and systemic (general) health? _____

_____

Are there any foods that you enjoy but cannot eat due to discomfort in your teeth? _____

_____

Do you experience any apprehension before or during your dental visits? If so, please explain.

_____

_____

_____

What quality of dentistry do you want us to focus on at this time?

☐ Patch it. ☐ Only what is covered by insurance. ☐ Ideal/Best available.

Should you be in need of treatment, at what point do you plan to begin treatment?

☐ When it hurts. ☐ When it breaks. ☐ When recommend in order to prevent further deterioration.

Has "fear" or "cost" ever prevented you from getting the dental treatment you **need**? ☐ Yes ☐ No

Has "fear" or "cost" ever prevented you from getting the dental treatment you **want**? ☐ Yes ☐ No

Getting To Know You

1. First Name: _____ Last:_____
2. How long have you lived in the area? _____
3. Occupation _____
4. Name of Spouse/Partner _____
5. Spouse's/Partner's Occupation _____
6. Children
    a. Name _____ Age _____
    b. Name _____ Age _____
    c. Name _____ Age _____
    d. Name _____ Age _____
7. Relatives who live in the area? _____ Parent(s) _____ Sibling(s)
   _____ Grandparent(s) _____ Other
8. Do you make health care decisions on your own? YES NO
   If no, who else is involved in your health care decisions?
   _____
9. Is a monthly payment plan important for assisting your treatment? YES NO

We offer several patient funding services such as Alphaeon Credit, Cherry Financing, Care Credit, and Sunbit Financing. Would you be interested to know more about it? ____ Yes _____ No

Please let us know what works best to fit your needs.

_____