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:** _____

CHILD DENTAL MEDICAL HISTORY

Patient's First Name: _____ Last Name: _____ M.I. ___
Nickname: _____ Date of Birth: _____
Parent's/Guardian's Name:

_____

DENTAL HISTORY - CIRCLE THE APPROPRIATE ANSWER

1. Is this your child's first visit to a dentist? **YES NO**
2. If not, how long since the last visit to the dentist? **YES NO**
3. Were any x-rays or radiographs taken when your child previously visited the dentist? **YES NO**
4. Does your child eat snacks between meals? **YES NO**
5. Does your child eat sweets, such as candy, soda, or chewing gum? **YES NO**
6. When does your child brush his/her teeth? ☐ In the morning. ☐ After eating any food. ☐ Right after meals. ☐ Before going to bed. **YES NO**
7. How does your child receive Fluoride? ☐ Community water level___ ppm. ☐ Fluoride drops or tablets. ☐ Well water level____ ppm. ☐ Fluoride rinse or gel. **YES NO**
8. Have any cavities been noted in the past? **YES NO**
9. Were any teeth (baby or permanent) removed by extraction? **YES NO**
   Was it suggested that the space be maintained?_____ **YES NO**
   Was an appliance placed?_____ **YES NO**
10. Have there been any injuries to teeth, such as falls, blows, chips, etc.?
    If so, describe: _____ **YES NO**
11. Has your child had any problem with dental treatment in the past? **YES NO**
12. Has anyone in the family, including parents, had orthodontics? **YES NO**
13. Has your child ever received a local anesthetic? **YES NO**
14. Has your child ever had occlusal sealants? **YES NO**
15. Does your child think there is anything wrong with his/her teeth? **YES NO**

MEDICAL HISTORY - CIRCLE THE APPROPRIATE ANSWER

1. Does your child have a health problem? **YES NO**
2. Is your child under the care of a physician? **YES NO**
   If yes, since when and why? _____
   Name & Tel. # of Physician:_____
3. Is your child receiving any medication? **YES NO**
   If yes, what medication? _____
4. Is your child allergic to penicillin, antibiotics, and other drugs? **YES NO**
5. Is your child allergic to or sensitive to any metals or latex? **YES NO**
6. Does your child have other allergies? _____ **YES NO**
7. Has your child had any serious illness? **YES NO**
   When? _____ What? _____
8. Has your child ever had surgery? **YES NO**
9. Does your child have a heart murmur? **YES NO**
10. Is surgery contemplated? **YES NO**
11. Does your child experience severe or prolonged bleeding? **YES NO**
12. Does your child have AIDS or has he/she tested HIV positive? **YES NO**
13. Has your child tested positive for hepatitis? **YES NO**
14. Is your child subject to nervous disorders? ☐ Fainting? ☐ Seizures? ☐Dizziness? ☐ Behavioral/Learning Problems? **YES NO**
15. Does your child have frequent headaches? **YES NO**
16. Has your child had a history of (check the appropriate responses): ☐ Diabetes ☐ Heart trouble ☐ Asthma ☐ Kidney infection ☐Rheumatic fever ☐ Epilepsy ☐ Cerebral Palsy ☐ Liver Problems ☐ Congenital Birth Defects ☐ Mental Disabilities ☐ Eyesight Problems ☐ Cancer ☐ Infections ☐ Speech Impairments ☐ Hearing Loss

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN'S SIGNATURE:

_____DATE_____

DENTIST'S SIGNATURE

_____DATE_____

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

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: **Care Credit, Alphaeon Credit, Sunbit Financing, Ally Lending, and Lending Club.**

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 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

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: _____