414 S. Prospectors Rd. Suite B, Diamond Bar, CA 91765
(909) 276-4404 office, (909) 354-3156 fax
office@hilodent.org

Patient Registration Form

Name: Last First Middle | Home Phone: *Include area code* ( ) | Business/Cell Phone: *Include area code* ( )

Address: Mailing address | City: | State: | Zip:

Occupation: | Height: | Weight: | Date of birth: | Sex: M F

Social Security# or UCI: | Emergency Contact: | Relationship: | Emergency Phone: ( ) *Include area codes* | Cell Phone: ( )

If you are completing this form for another person, what is your relationship to that person?

Your Name | Relationship | Conserved? (circle one): Y N | If so, do you have paperwork to prove this (circle one)? Y N

Insurance company name:

Policy #/Medi-Cal ID#:

Ethnicity: ☐ **White Caucasian** ☐**Asian** ☐**Hispanic** ☐**Black/African American** ☐**Other** _____

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*	**Yes**	**No**	**DK**
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information

	Yes	**No**	**DK**
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	**No**	**DK**
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:

What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information

	Yes	**No**	**DK**
Are you now under the care of a physician?	☐	☐	☐

Physician Name: | Phone: *Include area code* ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	**No**	**DK**
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

_____

_____

_____

_____

HiloDent

Medical Information (continued)

(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink In a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies - Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐

	Yes	No	DK
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: _____			
Recurrent Infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation: | Phone:

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐
Please explain:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: | Date:

*Adopted from American Dental Association, Form S500.

Form revised Feb 2020

General Informed Consent

General Information: I have elected to seek comprehensive dental care from HiloDent. If treatment will be more advanced than the clinic can provide, I may be provided with a list of low-cost dental clinics in the area as a referral. I also understand that dental care is provided by a licensed dentist and highly trained staff who are regulated by Dental Board of California. They can be reached by calling 877- 729-7789 or 916-263-2300 or emailing dentalboard@dca.ca.gov. I understand that I may ask questions regarding materials that may be used in dental procedures. I acknowledge that I have also received a copy of the "Patient Bill of Rights," "Dental Materials Fact Sheet," and the "Privacy Notice." I understand that the contact information I provide will be used to remind me of appointments. I also understand that the contact information will be used to have voicemails left.

Treatment Plan: I understand that the treatment plan that I accept is recommended dental treatment and that this plan could change. I understand that I am encouraged to ask my dentist questions about the procedures recommended. All dental procedures may involve risks and no guarantees are made to any treatment outcomes. As the patient, or parent or guardian, I have the right to consent or refuse any proposed procedures at any time. HiloDent also reserves the right to not perform specific treatment requested by a patient. My insurance will be billed if applicable. My insurance is a contract between myself, the insurance policy holder, and the insurance company. I will be responsible for all copays/deductibles under my contract with my insurance company. I understand that the insurance coverage are estimates and may not be accurate. I am expected to have my dental insurance billed and estimated copays paid on the same day of treatment. I also understand that the insurance may cover up to a certain amount and I am responsible for the difference in cost, if applicable.

After Hours Emergency Care: HiloDent does not have regular work hours. If an emergency or post operative complication arises after hours or on a weekend or holiday, I should call the HiloDent office at (909) 276-4404 to reach a dental professional. I can also refer to the list of the dental clinics in the area for assistance. If I am experiencing bleeding that will not stop or any life threatening emergency, I will go directly to my local emergency room.

Health: If I have any changes in my health status, changes in my medications or any recent hospitalizations, I will inform HiloDent. If I am taking a type of drug called bisphosphonates, I will inform my dentists as I may be at risk of developing osteonecrosis (bone death) of the jaw and certain dental treatments may increase that risk.

Keeping Appointments: I understand that it is my responsibility to keep appointments, and provide at least 48 hours notice if I have to cancel an appointment. If the appointment includes general anesthesia, I will be subject to a cancellation fee of $500.00. I also understand that if I continue to have failed/missed appointments for more than 3 times, I may will not be able to continue treatment at HiloDent. HiloDent reserves the right to discontinue my treatment.

Dental Records: I understand that the dental record, X-rays, photographs, models and any other diagnostic aids that relate to my treatment here, are the property of HiloDent. I acknowledge that I have the right to inspect these records and/or receive a copy of them or to request that they be sent to another health care provider. In order to obtain a copy of my records I will need to complete and sign a Release of Information form.

Images: my picture may be taken upon registration to confirm my identification on all future visits to dental clinic. I give HiloDent the right to use all audio and/or visual images captured during clinic for any educational, advertising, trade, promotional, or other lawful purpose related to HiloDent. I agree that HiloDent owns the copyright for these images and I waive all claims of invasion of privacy for defamation.

Consent: I consent to examination, X-ray, models, photographs, diagnostic testing for the development of my proposed treatment plan and I further consent to any treatment procedures, which are diagnosed and indicated on the treatment plan. I agree that all records are the property of HiloDent.

Release: I understand my dental health care is not under warranty, expressed or implied. In addition, I agree to release, hold harmless and waive all claims, losses or damages resulting or relating to the treatment rendered hereunder personnel at HiloDent.

My signature below indicates that I have read and understand the above information and am willing to comply with the foregoing, and that I am patient, the parent or guardian of the patient with authority to give consent, or that I am duly authorized by the patient as the patient's general agent to execute the above and accept it's terms.

Patient Name _____ Date_____
Signature of Patient/Parent or Guardian_____
Name of Parent/Guardian (if applicable)_____
Signature of Witness_____

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