

JOSEPH LEVINGSTON, D.D.S.
 385 N. COAST HWY
 LAGUNA BEACH, CA. 92651
 (949) 494-7115

PATIENT NAME _____ Date _____

Primary reason for this visit (circle one) Emergency Consultation Exam/Cleaning

Medical History Do you have or have you ever had any of the following? Please check the appropriate boxes

YES	NO		YES	NO	
_____	_____	Major Operation _____	_____	_____	Swollen Ankles, Feet or Hands
_____	_____	Serious Illness _____	_____	_____	Bleeding Tendency / Bruise easily
_____	_____	Diabetes: Self _____ Family Member _____	_____	_____	Kidney Disease or Infection
_____	_____	Cancer: Type _____	_____	_____	Hormone Problems
_____	_____	Radiation / Chemotherapy _____	_____	_____	Glaucoma
_____	_____	Leukemia _____	_____	_____	Arthritis or Gout
_____	_____	Heart Attack When: _____	_____	_____	Severe or Frequent Headaches
_____	_____	Heart Trouble or Heart Murmur (Circle One) _____	_____	_____	Nervousness, Stress or Tension
_____	_____	Heart Bypass Surgery When: _____	_____	_____	Psychiatric Care or Therapy
_____	_____	Chest Pains / Angina _____	_____	_____	Are You Pregnant or Nursing
_____	_____	Stroke When: _____	_____	_____	Do You Smoke / Chew Tobacco
_____	_____	High or Low Blood Pressure (Circle One) _____	_____	_____	Emphysema
_____	_____	Epilepsy / Convulsions _____	_____	_____	Asthma / Trouble Breathing
_____	_____	Hip or Joint Replacement When: _____	_____	_____	Rheumatic Fever
_____	_____	Any Prosthetics When: _____	_____	_____	Taken Fen-Phen or Redux
_____	_____	Taken Fosamax or Osteoporosis Medications _____	_____	_____	Allergies to Latex, metals acrylics
_____	_____	Herpes Infection _____	_____	_____	List All Allergies (Include drugs)
_____	_____	Venereal Disease _____	_____	_____	_____
_____	_____	Tuberculosis or Lung Disease _____	_____	_____	_____
_____	_____	HIV Positive/AIDS or exposed to _____	_____	_____	List All Current Medications
_____	_____	Stomach Ulcers / Stomach Problems _____	_____	_____	_____
_____	_____	Thyroid Problems _____	_____	_____	_____

Dental History Main Dental Complaint _____

YES	NO		YES	NO	
_____	_____	Do you like your smile?	_____	_____	Pack food between your teeth?
_____	_____	Do you want to keep your remaining teeth?	_____	_____	Clench or Grind your teeth?
_____	_____	Bleeding Gums?	_____	_____	Pain or popping in jaw joint?
_____	_____	Bad taste or odor	_____	_____	Burning tongue feeling
_____	_____	Tooth Sensitive to hot / cold / sweets	_____	_____	Orthodontic treatment
_____	_____	Loose Teeth	_____	_____	Bite Corrected by Grinding
_____	_____	Prolonged bleeding after extraction	_____	_____	Gum Boil or Abscess
_____	_____	Adverse reaction to Dental Anesthetics	_____	_____	Do you Snore?

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if medications change, I shall inform the Doctor and Staff at the next appointment without fail.

Patient Signature _____ Date _____

Reviewed By Doctor _____ Date _____

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PATIENT INFORMATION

Name _____ Sex: _____ Wt: _____ Ht: _____
Address _____ Marital Status _____
City _____ Zip Code _____ Date of Birth _____
Home Phone _____ Cell Phone _____
S.S. Number _____ E-Mail Address _____
Employer _____ Occupation _____
Employer Phone _____ Physician _____
How did you hear about us? _____ Date of last physical _____
Physician's Phone Number _____ Reason for last physical _____

PATIENT INSURANCE INFORMATION
PRIMARY CARRIER

Guarantor _____ Date of Birth _____
Address _____ S.S. Number _____
City, State, Zip _____ Group Number _____
Employer _____ Policy Number _____
Name of Insurance _____ Effective Date _____
Claim Address _____ Relationship _____
Do you have additional dental insurance? Yes ___ No ___ Guarantor _____
Carrier _____ Group# _____ Policy# _____

1. The undersigned hereby authorizes the doctor to order x-rays, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patients needs.
2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of Patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment. I understand that all responsibility for payment for dental services provided in this office for myself or my dependants is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payment is not received by the agreed upon dates, I understand that a 15% finance charge may be added to my account in addition to any finance charges.
3. I understand that where appropriate credit bureau reports may be obtained. I understand that it is my responsibility to advise your office of any changes of information obtained on this form. The undersigned hereby authorizes the release of any information relating to all claim or benefits submitted on behalf of myself or any dependants. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits for services rendered without obtaining my signature on each and every claim to be submitted for myself or my dependants and that I will be bound by this signature as though the undersigned personally signed that particular claim until this authorization is revoked.
4. I realize that my insurance may not pay 100% and I will be responsible for any balance not paid by the insurance.

Patient Signature _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

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GENERAL CONSENT AND INFORMATION FORM

It is the belief of this office that you should be informed of the treatment (therapy) we may recommend, and that you should give us consent before starting that treatment. The purpose of this form is to tell of the risks that may occur in dental treatment.

RISKS OF DENTAL TREATMENT IN GENERAL: Included but not limited to are complications resulting from the use of dental instruments, drugs, medications, analgesics (pain killers), anesthetics and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensation in the lip, tongue, chin, gums, cheek and teeth, thrombophlebitis (inflammation of a vein), reaction to injections. Change in occlusion (biting), muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of teeth or restoration in teeth, injury to the other tissues, referred pain to the ear, neck and head, nausea, vomiting, allergic reactions, itching, bruises, delayed healing, sinus complications, and further surgery. Medications and drugs may cause drowsiness and lack of awareness and coordination which can be influenced by the use of alcohol or other drugs, thus it is advisable not to operate any vehicle or hazardous device, or work for 24 hours or until recovered from their effects.

CHANGES IN TREATMENT PLAN: I understand during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the Dentist to make any/all changes, additions and/or deletions as the Dentist deems necessary.

I hereby request and authorize the Dentists and their staff, to perform dental work upon me for the purpose of attempting to improve my appearance, function and the health of my mouth, teeth, bone, and tissue and understand the risks involved, as well as the possible alternative methods of treatment that has been fully explained to me. I also authorize the operating dentist and assistants to perform any other procedure which they may deem necessary or desirable in attempting to improve my condition, or treat unhealthy or unforeseen conditions that may be encountered during treatment.

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the treatment I am requesting or authorizing. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other dentist, individual or corporation, other than the treating dentist, is responsible for my dental treatment. In order to receive treatment I agree that if there is any difference or disagreement between my attending dentist and myself I will first present such difference or disagreement to my attending dentist to resolve the problem. If we are unable to agree on a solution, then I agree to take the problem to a reconciliation board such as the grievance committee of my dental health plan, the Dental Society or California State Consumer Affairs Board of Dental Examiners, and agree to accept their resolution in lieu of pursuing remedies by way of litigation, in consideration of helping to keep the cost of treatment and services as low as possible. I also understand that this agreement is binding on my heirs and all other family members.

Alternatives and possible unforeseen reactions have been explained to me clearly and in detail, including but not limited to bleeding, scarring, numbness, fractured jaw, and allergic reactions which on occasion can be life threatening. I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT AND THAT EXPLANATIONS THEREIN REFERRED TO WERE MADE. ANYTHING I DID NOT UNDERSTAND HAS BEEN EXPLAINED TO ME.

Signature of Patient or Legal Guardian/Representative

Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**JOSEPH LEVINGSTON, D.D.S.
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Notice to patient

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign this acknowledgement if you wish.

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I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Please print your name here

_____ I authorize your dental office to leave messages on my answering machine, voice mail, e-mail and /or with a family member regarding my appointments.

Signature

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices from this patient but could not because:

- _____ Patient refused to sign.
- _____ Due to emergency situation it was not possible.
- _____ We were not able to communicate with the patient.
- _____ Other (provide specific details)

Employee Signature

Date