TURNER DENTAL
premium care

Jeff Turner, DDS
2 Journey, Suite 107
Aliso Viejo, CA 92656
TurnerDentalCare.com

PATIENT INFORMATION

Name: _____ Birth Date: _____

Mobile #: _____ Home #: _____

Email: _____ SS#: _____

Home Address: _____ City: _____ Zip: _____

Employed by: _____ Work Phone #: _____

Spouse Name: _____ Who pays for this account? _____

How did you hear about us? _____

INSURANCE INFORMATION

Dental Insurance Carrier: _____ Insurance Phone # _____

Insured/Employee Name: _____ Insured Birth Date: _____

Group Number: _____ Insured/Employee SS#: _____

Employed by: _____ Position: _____

Do you have secondary insurance? ☐Yes ☐No Carrier: _____

MEDICAL HISTORY

Have you ever had or do you currently have?

	Y	N
Are you in good health?	☐	☐
Allergies to:	☐	☐
Penicillin	☐	☐
Local Anesthetic	☐	☐
Antibiotics/Other Drugs (Please List)	☐	☐
_____		
_____		
Abnormal Bleeding	☐	☐
Heart Disease	☐	☐
Angina(chest pain) or Pacemaker	☐	☐
Rheumatic Heart Disease	☐	☐
High Blood Pressure	☐	☐
Joint or Valve Replacement	☐	☐
Pregnant or Nursing	☐	☐
RespiratoryProblems (difficulty breathing)	☐	☐
Asthma or Tuberculosis	☐	☐
Hepatitis (A or B)	☐	☐

	Y	N
Are you presently under Medical Treatment?	☐	☐
(explain) _____		
Do you have any serious health conditions?	☐	☐
(explain) _____		
History of Cancer or Tumor	☐	☐
Diabetes	☐	☐
AIDS or HIV	☐	☐
Marked weight change	☐	☐
Do you take any of the following medications?	☐	☐
Blood thinners, Aspirin, Coumadin, Fosemax, Heart Medications, Nitroglycerin, Illicit Drugs		
Other Medications? (Please List)	☐	☐
_____		
_____		
_____		
_____		

My Medical Doctor's Name: _____ Doctor's Phone #: _____

Patient Signature (or legal guardian) _____ **Date** _____

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PATIENT DENTAL INFORMATION

Name: _____ Date: _____

Initial Concern: _____

_____

If you could change one thing about your smile, what would it be? _____

_____

DATE OF LAST DENTAL VISIT	DATE OF LAST DENTAL CLEANING	DATE OF LAST SET OF DENTAL X-RAYS

Mark yes for any of the following if they apply or have applied to you.

	YES
1. Do you have any Dental problems now?	☐
2. Are you dissatisfied with the appearance of your teeth?	☐
3. Do you have mouth pain?	☐
4. Do you have any broken teeth?	☐
5. Do you have teeth that are sensitive to	
Hot or cold?	☐
Sweets?	☐
Biting or chewing?	☐
6. Have you ever had:	
a. Orthodontic Treatment?	☐
b. Oral Surgery?	☐
c. Periodontal Treatment?	☐
d. A night guard or other appliance?	☐
7. Have you noticed any loosening or movement of your teeth?	☐
8. Does food tend to become caught between your teeth?	☐
9. Are you concerned with bad breath?	☐
10. Do you have pain and/or swelling of your gums?	☐
11. Do your gums often bleed when you brush your teeth?	☐
12. Do you ever get sores in your mouth?	☐
13. Do you have sinus problems/infections?	☐

	YES
14. Is there any history of allergy to latex?	☐
15. Have you experienced:	
a. Clicking of the jaw?	☐
b. Pain (joint, ear, side of face)?	☐
c. Difficulty in opening or closing?	☐
d. Difficulty in chewing?	☐
16. Do You:	
a. Smoke or Chew tobacco?	☐
b. Clench or grind your teeth while awake or asleep?	☐
c. Bite your lips or cheeks regularly?	☐
d. Hold foreign objects with your teeth (such as pencils, pipe, pins or fingernails)?	☐
e. Mouth breathe while awake or asleep?	☐
f. Regularly suck on candy or mints?	☐
17. Do you have a history of gagging during dental treatment?	☐
18. Is there anything about your mouth that concerns you?	☐
19. Is there anything about having dental treatment that concerns you?	☐
Please explain:	
_____	
_____	
_____	

Patient Signature (or legal guardian) _____ **Date** _____

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OFFICE POLICIES

APPOINTMENTS: Please remember, appointment time is reserved exclusively for you. This enables us to better serve each patient. If it becomes necessary, please reschedule or cancel appointments with our office at least two business days in advance. Our office assesses a charge for the time lost due to a late cancellation or missed appointment. As a courtesy, a voice message, text or email reminder concerning appointment information will be left at the phone number/ email address you provide.

FINANCES: Payment is due at the time services are rendered. We accept cash, checks, Visa, MasterCard, and American Express. A $20 monthly late fee and an interest charge (18% annual percentage rate) will be assessed on all past due accounts. A bank fee will be charged on all returned checks.

DENTAL INSURANCE: As a courtesy to you, we will bill your insurance company for treatment rendered. However, it is the patient's responsibility to know the current status of their insurance coverage and benefits. Our staff will estimate your co-payment based upon the policy information provided by you. This amount will be due at the time of treatment. Actual coverage may vary from our estimate, as your insurance carrier ultimately determines participant eligibility and claim benefits. The financial responsibility for the work you receive in our office is strictly between you and Dr. Turner, regardless of insurance participation.

- **I understand and agree to the foregoing office policies and I hereby agree to accept responsibility for full payment of all treatment fees regardless of any insurance payment or participation.**

- **I consent to any and all examination and treatment which may be deemed advisable, including the administration of local anesthetics and other medications.**

- **I consent to having the dental office use my cell phone number to call or text me regarding treatment, appointments, my dental insurance and my account. I understand I can withdraw my consent at any time.**

- **In addition, I hereby acknowledge that I have been given the right to review a copy of this office's *Dental Materials Fact Sheet* and the *Notice of Privacy Practices* as required by California State law.**

_____ _____

Signature of Patient or Responsible Party **Date**