Welcome to our office

Rodney P. Burton, D.D.S.

Today's Date: ________________

Name: ____ Gender: ________
Last First

Birthday: _______/_______/_______ Age: __________ SSN: ______ - ______ - ______

Driver's License: ______________________ Email Address: ______________________________

Home Address: ____
Street City State Zip

Home/Cell Number: (_____) _______ - ________ Work Number: (______) _____ - ______ Ext: _____

Employer: ____ Occupation: _______________

How did you hear about us? Internet/Referral/Other Referred by: _______________________________

Other family members seen by us: ____

Emergency Contact Information:

Name: ________________________ Relationship: __________ Phone Number: (____) _____ - _____

Dental Insurance Information:
Please give your card to the front desk to make a copy of as well as your Driver's License.

Insurance Company: ______________________________ Phone Number: (_____) ______ - ______

Subscriber's Name: ______________________________ Subscriber's Birthday: _____/_____/_____

ID Number/SSN: ______________________________ Group Number: ____________________

Relationship: ______________________________ Employer: __________________________

__________ **(Initial)** I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

Privacy Practices and Dentals Materials Fact Sheet

I, the undersigned, have read, and I understand both the Notice of Privacy Practices and the Dental Materials Fact Sheet.

Signature: ____ Date: __________________

Texts & E-mails

Dr. Rodney P. Burton, DDS sends out e-mail and text message appointment reminders. If you opt in, you are authorizing Demand Force to send these reminders to you.

****If left blank you will be automatically opted in****
Text messages: Opt in / Opt Out E-mail: Opt in / Opt Out

****PLEASE MAKE SURE TO FILL OUT BOTH SIDES****

Welcome to our office

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Dental History

Previous/Current Dentist: ______________________________ Date of last visit: ______________

Why have you come to the dentist today? ____

Are you currently in pain	Yes	No	Have you ever had periodontal disease?	Yes	No
Do you floss daily	Yes	No	Do you have loose teeth	Yes	No
Do you brush daily	Yes	No	Do you clench or grind your teeth	Yes	No
Do your gums ever bleed	Yes	No	Have you had any orthodontic work	Yes	No
Do your gums ever itch	Yes	No			

Your current dental health is? (Please Circle)	Good	Fair	Poor
Are your teeth sensitive to any of the following?	Heat	Cold	Chewing
Are you satisfied with the appearance of your teeth?	Yes	No	
- If no, what would you like to change? (Please Circle)	Length	Shade	Spacing or crowding
Have you experienced any of the following? (Please Circle)	Clicking	Pain	Difficulty opening or closing
Do you clench or grind your teeth?	Yes	No	
Do you need to pre-medicate before dental appointments?	Yes	No	
Previous serious complications with prior dental treatments?	Yes	No	

Sleep

Do you snore?	Yes	No	Have you been diagnosed with sleep apnea?	Yes	No
Have you been told you snore?	Yes	No	Do you have a CPAP Machine?	Yes	No
Have you ever had a sleep apnea test?	Yes	No	Do you have an Oral Appliance?	Yes	No

Medical History

Physician's Name: ______________________________ Phone Number: (______) ________ -__________

Pharmacy Name: ______________________________ Phone Number: (______) ________ -__________

Current Health: (Please Circle)	Good	Fair	Poor			
Any recent surgeries?	Yes	No		If yes, what kind of surgery and when?	________	
Have you ever taken bisphosphonates? (i.e. Boniva, Actonel, Fosamax)	Yes	No		If yes, which kind?	IV	Oral
For Women: Are you pregnant?	Yes	No		Are you nursing?	Yes	No

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Do you or have you experienced the following?

Abnormal Bleeding	Y	N	Emphysema	Y	N	Lupus	Y	N
Alcohol Abuse	Y	N	Epilepsy	Y	N	Mitral Valve Prolapse	Y	N
Anemia	Y	N	Fainting Spells	Y	N	Pacemaker	Y	N
Anxiety	Y	N	Glaucoma	Y	N	Persistent Cough	Y	N
Arthritis	Y	N	Hay Fever	Y	N	Psychiatric Problems	Y	N
Artificial Bones/Joints	Y	N	Headaches	Y	N	Radiation Treatment	Y	N
Artificial Valves	Y	N	Heart Attack	Y	N	Rheumatic Fever	Y	N
Asthma	Y	N	Heart Murmur	Y	N	Seizures	Y	N
Blood Transfusion	Y	N	Heart Surgery	Y	N	Shingles	Y	N
Cancer	Y	N	Hemophilia	Y	N	Sickle Cell Disease	Y	N
Chemotherapy	Y	N	Hepatitis	Y	N	Sinus Problems	Y	N
Chicken Pox	Y	N	Herpes	Y	N	Steroid Therapy	Y	N
Colitis	Y	N	High Blood Pressure	Y	N	Stroke	Y	N
Congenital Heart Defect	Y	N	High Cholesterol	Y	N	Thyroid Problems	Y	N
Depression	Y	N	HIV+/AIDS	Y	N	Tuberculosis (TB)	Y	N
Diabetes	Y	N	Kidney Problems	Y	N	Ulcers	Y	N
Difficulty Breathing	Y	N	Liver Disease	Y	N	Venereal Disease	Y	N
Drug Abuse	Y	N	Low Blood Pressure	Y	N		Y	N

Are you allergic to the following?

Aspirin	Y	N	Erythromycin	Y	N	Sedatives	Y	N
Barbiturates	Y	N	Jewelry/Metals	Y	N	Sulfa Drugs	Y	N
Codeine	Y	N	Latex	Y	N	Tetracycline	Y	N
Dental Anesthetics	Y	N	Penicillin	Y	N	Other	Y	N

Please list any other allergic reactions: ____

Prescribed Medications

Drug Name: ______________________ Purpose: ______________ Strength: ________

Drug Name: ______________________ Purpose: ______________ Strength: ________

Drug Name: ______________________ Purpose: ______________ Strength: ________

Drug Name: ______________________ Purpose: ______________ Strength: ________

Drug Name: ______________________ Purpose: ______________ Strength: ________

Drug Name: ______________________ Purpose: ______________ Strength: ________

Drug Name: ______________________ Purpose: ______________ Strength: ________

Authorization:

I, the undersigned patient, affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office, Dr. Rodney P. Burton, DDS, of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I understand that I am responsible for payment of services rendered. As a courtesy, we will file your dental insurance as an out of network provider, so you may receive reimbursement. I have received a copy of this office's Notice of Privacy Practices. We use this information to provide you with excellent treatment. We may disclose Patient Health Information (PHI) to third parties that perform services for Dr. Rodney P. Burton, DDS in the administration of your benefits in accordance with HIPAA. Our affiliates do not sell, share or rent our users' personally identifiable information unless required by law, do not send any e-mail or other communications without user permission, and do not send spam.

Patient Signature: ______________________________________ Date: ____________

Doctor Signature: ______________________________________ Date: ____________

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Rodney P. Burton DDS 228 Lombard Street Suite C Thousand Oaks, CA 91360 (805) 494-1500

Welcome to our office

Rodney P. Burton, D.D.S.

HIPAA Consent to Share Dental Information

If you would like to authorize your information to be shared with anyone, including spouse & parents, please fill out the below.

I, ____________________________ authorize, Dr. Rodney P. Burton, DDS, to share the below indicated information to the following person(s):
(Print your name)

Name: ____ Relationship: ______________________

Name: ____ Relationship: ______________________

Name: ____ Relationship: ______________________

Please indicate the information that we may share:

( ) Making appointments
( ) Confirming appointments
( ) Discussing treatment needed and/or preformed
( ) Account or Financial Information
( ) Make payments
( ) Insurance information/benefits

This consent will remain valid from here forward unless otherwise informed by the patient and a new form is filled out

Signature: ____ Date: ___________________

If you <u>do not</u> authorize to have your information shared with anyone, please fill out below:

I, ____________________________________ do ***not*** authorize to have my information shared with anyone, including my spouse/partner, or any other family member, friends or guardian please sign and date below:
(Print your name)

This consent will remain valid from here forward unless otherwise informed by the patient and a new form is filled out

Signature: ______________________________________ Date: _______________

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