REGAL DENTISTRY & ORTHODONTICS

Beautiful Smiles Begin Here!

3950 PIERCE STREET, SUITE L
RIVERSIDE, CA 92505
WWW.REGALDENTISTRY.NET
TEL: 951-688-0082

PATIENT INFORMATION

Date: ____________________ ☐ NEW PATIENT ☐ UPDATE

Patient: ____
LAST FIRST MI PREFERRED

Patient Date of Birth: ____________________________ Patient SSN: ____________________________

☐ MALE ☐ FEMALE ☐ CHILD(MINOR)* PARENT/GUARDIAN NAME(S) : ____________________________ ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

Address: ____ HOME: ______________
STREET

____ CELL: ______________
CITY ST ZIP CODE

Email: __________________________________

HOW DID YOU HEAR ABOUT US? ☐GOOGLE ☐YELP ☐WEBSITE ☐PRINT AD/MAILER ☐OTHER

REFERRED BY: _______________________________________

INSURANCE INFORMATION/RESPONSIBLE PARTY

Subscriber (Insured):________________________________ ☐ SELF ☐ SPOUSE ☐ PARENT

Subscriber SSN: ________________________________ Subscriber DOB: ____________________

Insurance Company: ________________________________ Phone #: ______________________________

Member ID: _________________________ Group #: ______________________

Secondary Ins: ______________________

MEDICAL HISTORY

GENERAL HEALTH: ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

☐Y☐N Under a Physician's care now? If Yes PHYSICIAN'S NAME: ______________________________

PHYSICIAN'S ADDRESS: __________________________ PHONE NUMBER: ______________________________

☐Y ☐N Any hospitalization in the past 5 yrs? If Yes: ______________________________________

☐Y ☐ N Any serious illnesses/surgeries? If Yes: ______________________________________

☐Y ☐ N Use tobacco in any form? If Yes: Type: __________________How Long:________

☐Y ☐ N Use Recreational Drugs in any form? If Yes: Type: __________________How Long:________

☐Y ☐ N Have you ever taken Phen-Fen or Redux?

☐Y ☐ N Have you ever taken osteoporosis or bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs?

☐Y☐ N Is pre-medication required before dental visits due to heart condition or artificial joint?

FEMALE PATIENTS: ☐Y ☐N Currently nursing? ☐Y☐N Currently pregnant? ☐Y☐N Taking Oral Contraceptives?

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐ Y ☐ N
If yes, please describe:

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ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK YES OR NO ON ALL):

YES/NO	YES/NO	YES/NO	YES/NO
☐/☐ AIDS/HIV	☐/☐ CHEMICAL DEPENDENCY	☐/☐ HEPATITIS	☐/☐ RHEUMATIC FEVER
☐/☐ ADHD	☐/☐ CHEST PAIN	☐/☐ HERPES	☐/☐ SCARLET FEVER
☐/☐ ALZHEIMER'S/DEMENTIA	☐/☐ COLD SORES/BLISTERS	☐/☐ HIGH BLOOD PRESSURE	☐/☐ SHINGLES
☐/☐ ANAPHYLAXIS	☐/☐ CORTISONE MEDICINE	☐/☐ HIGH CHOLESTEROL	☐/☐ SINUS PROBLEMS
☐/☐ ANEMIA	☐/☐ DEPRESSION	☐/☐ HIVES/RASHES	☐/☐ SPINA BIFIDA
☐/☐ ANGINA	☐/☐ DIABETES	☐/☐ KIDNEY DISEASE	☐/☐ STDS
☐/☐ ARTIFICIAL HEART VALVE	☐/☐ EMPHYSEMA	☐/☐ LIVER PROBLEMS	☐/☐ STROKE
☐/☐ ARTIFICIAL JOINTS	☐/☐ EPILEPSY/SEIZURES	☐/☐ LOW BLOOD PRESSURE	☐/☐ SUBSTANCE ABUSE
☐/☐ ARTHRITIS/GOUT	☐/☐ EXCESSIVE BLEEDING	☐/☐ LUNG DISEASE	☐/☐ THYROID CONDITION
☐/☐ ASTHMA	☐/☐ FAINTING/DIZZY SPELLS	☐/☐ MITRAL VALVE PROLAPSE	☐/☐ TUBERCULOSIS
☐/☐ BLOOD DISEASE	☐/☐ GLAUCOMA	☐/☐ OSTEOPOROSIS	☐/☐ TUMORS/GROWTHS
☐/☐ BLOOD TRANSFUSION	☐/☐ HAY FEVER	☐/☐ PACEMAKER	☐/☐ ULCERS
☐/☐ BRUISE EASILY	☐/☐ HEART ATTACK	☐/☐ PSYCHIATRIC TREATMENT	☐/☐ VENEREAL DISEASE
☐/☐ CANCER/MALIGNANCY	☐/☐ HEART DISEASE	☐/☐ RENAL DIALYSIS	☐/☐ YELLOW JAUNDICE
☐/☐ CHEMO/RADIATION	☐/☐ HEART MURMUR	☐/☐ RESPIRATORY DISEASE	☐/☐ OTHER, LIST BELOW:

Is there anything important about your medical condition we have not asked? ☐ Y ☐ N If yes, please describe:

ALLERGIES/ALLERGIC REACTIONS

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK YES OR NO ON ALL):

YES/NO	YES/NO	YES/NO	YES/NO
☐/☐ ASPIRIN	☐/☐ CODEINE	☐/☐ LATEX	☐/☐ PENICILLIN/OTHER ANTIBIOTICS
☐/☐ ANESTHETIC – LOCAL	☐/☐ DAIRY	☐/☐ METAL SENSITIVITY	☐/☐ SULFA DRUGS
☐/☐ BARBITURATES/SEDATIVES	☐/☐ IBUPROFEN		
☐/☐ OTHER – PLEASE LIST			

MEDICATION INFORMATION

ALL PATIENTS: LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE ALL PRESCRIPTION AND OTC DRUGS/ MEDICATIONS (INCLUDING ANY VITAMINS):

☐NONE

DRUG NAME	DOSAGE	REASON PRESCRIBED

EMERGENCY CONTACT NAME:	PHONE NUMBER:

PATIENT CONSENT

To the best of my knowledge, all of the preceding answers are correct. I understand that providing incorrect information can be dangerous to my (or patient's) health. If I have any changes in my health status or if my medication(s) changes, I shall inform the dentist and staff at the next appointment without fail.

Signature: ______________________ **DATE:** ______________

RELATIONSHIP TO PATIENT: ☐SELF(ADULT PATIENT) ☐PARENT ☐GUARDIAN

Dental and Oral Health Information

Please Describe Any Specific Dental Problem or Discomfort You Are Having at This Time:

____ How Long Has It Been Present? ________________

If You Have Had Any of the Following Dental Care Please List the Dentists and Approximate Dates:

Periodontal (Gum) Treatment or Surgery: ____

"Braces" or Any Type of Orthodontic Treatment: ____

Dental Implants: ____

Any Other Type of Oral Surgery: ____

Do You Have or Had Any of the Following or Noticed Any of These Signs or Symptoms in Your Head, Neck, or Mouth?

(Please Check Yes or No for Each Question)

	Yes	No
Teeth that are Sensitive to:		
Hot, Cold, Sweets, or Biting Pressure	___	___
An Unpleasant Taste or Persistent Bad Breath	___	___
Does Food Catch Between Your Teeth	___	___
Do Your Gums Bleed When Brushing	___	___
Red, Swollen, Tender, Bleeding, or Sore Gums	___	___
Gums That Have Pulled Away from the Teeth	___	___
Pus Between the Teeth and Gums	___	___
Avoid Any Area When Brushing or Chewing	___	___
Do You Clench or Grind Your Teeth	___	___
A Clicking, Snapping or Difficulty When Chewing	___	___
Difficulty Opening or Moving the Jaws	___	___
Difficulty Speaking or Changes in Your Voice	___	___
Difficulty Moving Your Tongue or "Tongue Tied"	___	___
Loose or Separating Teeth	___	___
Changes in the Way Your Teeth Fit Together	___	___
A Color Change of the Tissues in Your Mouth	___	___
Pain, Tenderness, Numbness, or Earaches	___	___
Any Lumps Swelling or Swollen Glands	___	___
Sores, Ulcers, or Rough Spots in Your Mouth	___	___

About Your Dental Health:

How Do You Rate Your Overall Dental Health? ☐Good ☐Fair ☐Poor

How Many Times a Day Do You Brush Your Teeth? _____ **How Many Times a Week Do You Floss Your Teeth?** _____

Do You Use Any of the Following? (Please Check Yes or No for Each Question)

	Yes	No
Power / Mechanical / Electric Toothbrush	___	___
If Yes, What Type or Brand? ☐Sonicare ☐Oral-B/Braun ☐Disposable ☐Other____________		
Flossing Aids (Floss Holders, Threaders, etc.)	___	___
Oral Irrigating Device (Water Pik)	___	___
Fluoride Treatments or Supplements at Home. If Yes, What: ____________________	___	___
Mouthwashes or Oral Rinses. If Yes, What Brand? ____________________	___	___
Do You Have Any Missing Teeth That Have Not Been Replaced?	___	___
Why Have You Not Had Them Replaced?____________________		
Do You Wear Any Removable Dental Appliances? If Yes, What Type and For How Long? ____________	___	___
Have You Ever Had Your Teeth Whitened or Bleached?	___	___
Would You Like to Have Your Teeth Whitened or Bleached?	___	___

How Do You Feel About the Appearance of Your Smile and What Would You Change If You Could?

____

	Yes	No
Are You Concerned About the Finances Required to Return Your Mouth to Excellent Health?	___	___
Are You Frustrated Because You Always Need Something Treated or Repaired When You Visit a Dentist?	___	___
Do You Feel You Will Eventually Wear Artificial Dentures?	___	___
Have You Ever Had Any Complications From an Extraction or Dental Treatment?	___	___
If Yes, Please Explain: ____________________		
Have You Ever Had Any Other Dental Conditions, Major Trauma or Injury to Your Head, Neck, or Mouth?	___	___
If Yes, Please Specify: ____________________		

If You are a New Patient to this Practice:

Date of Last Dental Visit: _________ Dentist's Name: ____________________ City & State: ____________

Signature: ____ **Date:** ________________

INFORMED CONSENT

Patient name: ____

Medical History Information
Please understand that it is important that you divulge any information about your medical history to your dentist. It is important that you inform us of any medicines that you are taking each time that you come to an appointment as some medications can cause harmful reactions with dental anesthetics, analgesics, antibiotics or other medications. Please be sure to provide us with a list of any drug allergies you have.

Restorations
I understand that care must be exercised in chewing on fillings until directed by doctor or staff to avoid breakage or soft tissue damage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that sensitivity may occur after a newly placed filling.

Changes in Treatment Plan
I understand that 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, for example, root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary after consultation.

Complications
Complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections include (but are not limited to) swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth (which is transient but on infrequent occasion, may be permanent), reaction to injections, changes in occlusion (biting), jaw muscle cramps and spasms, temporomandibular (jaw) difficulty, referred pain to ear, neck, and head, nausea, vomiting, allergic reactions, delayed healing and treatment failure.

X-rays and photos
Modern dental x-ray equipment is extremely low-dose radiation. Diagnostic x-rays provide the dentists with valuable information about your teeth and supporting bone that cannot be evaluated otherwise. Our office takes the minimum x-rays to allow us to do a thorough exam for each patient. All patients 18 years and older will receive a full mouth series of intra-oral x-rays. Without these x-rays, we cannot do a complete exam of the entire mouth and jaw. We may also take photos of our patients as part of their permanent record. We will not release these photos to anyone without your permission.

Requests for records/x-rays
By law we are required to keep a patient's original x-rays and record in this office. Original x-rays or records will **NOT** be released. The patient or a designated person may request copies of their x-rays or record, however, there is a fee for duplication. We also require a minimum of 5 days notice to copy x-rays. There is no fee for us to send x-rays to a specialist that we refer you to.

Specific Problem Examinations
In the event that a patient requests only a specific problem be addressed (i.e.: broken tooth, pain in one area, etc.) this is considered a problem focused evaluation. X-rays will be taken in this specific area only, and a complete comprehensive examination will not be done. The dentist cannot diagnose problems in other areas of the mouth. Please understand that this appointment will be for the treatment/diagnosis of an emergency/urgent need. Any future treatment of other areas will require additional x-rays and a complete exam.

Specialty Referral and/or Second Opinion
General dentists perform the majority of all dental treatment today. However, we want all patients to be aware that specialty fields exist in dentistry, particularly in the fields of oral surgery, orthodontics, periodontics, pediatric dentistry, and endodontics. In some cases we may have to refer certain procedures out to a specialist. We would be happy to offer you the names of specialists in order for you to have a second opinion and/or have actual treatment performed by a specialist.

I hereby authorize the dental staff of Regal Dentistry to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfactions. I consent to allow Regal Dentistry to take x-rays and perform an examination on me today.

Patient or Guardian Signature:____ **Date:** __________

Doctor Signature:____ **Date:**__________

Witness Signature:____ **Date:**__________

Patient Acknowledgement of Receipt of Dental Materials Fact Sheet and Notice of privacy Practices

As of January 1, 2002, the Dental Board of California requires that we distribute to our patients a copy of The Dental Material Fact Sheets. In addition, The Health Insurance Portability and Accountability Act (HIPPA) requires, effective April 14, 2003, that patients be given a copy of our Notice of Privacy Practice.

Please print and sign your name below.

I, ____, acknowledge that I have received from this office:

1. A copy of the Dental Materials Fact Sheet
2. The Notice of Privacy Practice, Health Insurance Portability & Accountability Act of 1996 ("HIPPA")

Signed: ____ Date: ________________
Patient or Legal Guardian/Representative's Signature

**************************************FOR OFFICIAL USE ONLY***********************************

If sign by a personal representative of the patient, describe the representative's authority to act for patient.
____
____
.

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual Refused to Sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify):

____
____.

Financial Policy

Our fees are based on the quality of the products and materials we use and our experience in performing your scheduled treatment. Our goal is not to let expense prevent you from benefiting from the quality of care you desire and need. We also realize that every patient's financial situation is different.

Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs.

- We ask for payment at the time of service. Cash, Check or Credit Card will be collected at the time of service. Regal Dentistry also offers financing through 2 different third-party agencies; Care Credit and Lending Club. These companies offer low, and in some cases, no interest payment plans. You can apply online at www.carecredit.com, www.lendingclub.com, you usually receive approval in less than 5 minutes. We can also set up an automatic monthly withdrawal from your personal credit card account.
- For patients who have insurance, the entire estimated patient portion is due at the time of service. We ask that you read and be aware of your insurance benefits, exclusions and frequency limitations. Every plan is different and changes do occur frequently. We will perform an initial insurance verification and do our best to provide you an estimate of your co-pay prior to your appointment. If you are covered by 2 insurance companies, you need to be aware of a duplication clause and verify whether or not your secondary insurance has standard coordination of benefits or not. This may limit your secondary insurance payment.
- As a courtesy, we will gladly process your insurance claims and estimate the amount not covered by your insurance. All incurred charges are ultimately the responsibility of the patient regardless of insurance coverage and are due within 45 days of service. Any balance over 90 days old will be subject to a 5% monthly finance charge.
- Returned checks for insufficient funds or closed accounts are subject to a $40.00 fee. If a check is returned, cash, Visa, or MasterCard will be the only accepted form of payment. Refunds on Care Credit or Lending Club accounts will be subject to a 10% fee deduction of the total balance.
- 24-hour notice is required for any cancellation or rescheduled appointment. For missed appointments, we reserve the right to charge a missed appointment fee of $50.00.
- If a collection agency becomes involved in the settlement of your account, all collection costs and legal fees for both parties are the responsibility of the account holder.

I authorize my dental office to use, disclose and release personal health, medical and dental information only to other dentists, physicians, insurance carriers and healthcare finance companies for the purpose of treatment, treatment options, determination of eligibility, payment, healthcare operations, utilization review and financial audits.

I hereby authorize my insurance carrier to pay directly to Regal Dentistry (Jose Joel Manalese DDS Inc) the dental benefits otherwise payable to me. In the event that my dental insurance carrier should not pay the full amount estimated for any services rendered, I agree to be financially responsible for the remaining balance. I understand that the amount quoted to me as my portion for dental services is an estimate only and may vary according to the limitation and policies of my particular insurance company. I also understand that any overdue balance on my account will be subject to billing and/or finance charges.

My signature below certifies that I have read and understand the terms of the Financial and 24-hour cancellation policy listed above.

Printed Name: ________________________________

Signed: ____ **Date**: ______________________________

Patient or Legal Guardian's Signature

ARBITRATION AGREEMENT

Article 1

It is understood that any dispute as to dental/medical malpractice, that is as to whether any dental/medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2

a) Parties To The Agreement. The term "Patient" as used in this Agreement includes the undersigned individual, his or her spouse, children(whether born or unborn), and heirs, assigns, or personal representatives. The individual signing this Agreement signs it on behalf of the foregoing persons, and intends to bind each of them to arbitration to the full extent permitted by law.

The term "Doctor" as used in the Agreement includes the undersigned Doctor and his or her professional corporation or partnership, all independent contractors who practice dentistry at the undersigned Doctors place of business, and any employees agents, successors-in-interest, heirs and assigns of the foregoing individuals or entities. The Doctor signing this Agreement signs it on behalf of all the foregoing individuals and entities, intends to bind each of them to arbitration to the full extent permitted by law.

b) Treatment Covered. Patient understands and agrees that any dispute of the sort described in Article 1 between Doctor and Patient will be subject to compulsory, binding arbitration.

c) Other Doctors (if Applicable). Patients understands that he or she may at times receive treatment from one or more Doctors who are independent contractors practicing at the same facility as the undersigned Doctor. It is understood and agreed that any dispute of the sort described in Article 1 between Patient and such Doctors practicing at the same facility as the undersigned Doctor will be subject to compulsory, binding arbitration.

d) Coverage of Prenatal Claims (if Applicable). Patient understands and agrees that, if Doctor treats her during pregnancy, any dispute of the sort described in Article 1 as to (medical/dental) treatment which is claimed to have affected the unborn child will be subject to compulsory, binding arbitration.

Article 3

a) Informal Resolution of Disputes. In the event Patient feels that a problem has arisen in connection with the medical/dental care rendered by Doctor to Patient, Patient will promptly notify Doctor so that Doctor may have the opportunity to resolve the matter. Notice may be given orally or in writing, and shall stop the running of the statute of limitations for 90 days.

b) Method of Initiating Arbitration. If the dispute is not resolved by mutual agreement within 10 days of the expiration of the 90 days, Patient shall notify Doctor in writing of his or her desire to arbitrate and shall designate an arbitrator. Within 20 days of receipt of such notice, Doctor will designate an arbitrator to act on Doctor's behalf. In this event that more than two parties participate, all plaintiffs agree on one arbitrator, all defendants agree on one arbitrator and those arbitrators select a neutral arbitrator. The controversy shall than be submitted to the three arbitrators for a final and binding decision.

c) Applicable Law The arbitration shall be conducted pursuant to the California Arbitration Act. (C.C.P 1280-1295.) The arbitrators shall, in addition, have authority to order such other discovery as they deem appropriate for a full and fair hearing of the case. A determination on the merits shall be rendered in accordance with the law of the State of California including the provisions of the medical Injury Compensation Reform Act of 1975 which shall apply to the same extent as if the dispute were pending before a superior court of this State.

d) Interpretation of Agreement. Any controversy concerning the interpretation or application of the Agreement itself shall also be submitted to arbitration in the manner provided above.

Article 4

Revocation. If you sign this Agreement and then change your mind, the law permits you to revoke the Agreement, providing you give your Doctor written notice within 30 days from signing that you want to withdraw from the Agreement. However, Doctor and Patient agree that any claim arising from dental/medical services rendered prior to revocation shall be subject to arbitration.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL/DENTAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO JURY OR COURT TRIAL.SEE ARTICLE 1 OF THIS CONTRACT.

Patient's Name (Printed):_____________________________ Signature:_____________________________ Date:__________

Provider's Name (Printed):_____________________________ Signature:_____________________________ Date:__________