Dr. Dollins

Patient Information (confidential)

Date:_____

Name:_____ Birthdate_____ Referred by:_____

Address_____ City_____ State_____ Zip_____

HomePhone_____ CellPhone_____ Email_____

Occupation_____ Employer_____ Work Phone_____

Check Appropriate Boxes: ☐Male ☐Female ☐Minor ☐ Single ☐Married ☐Divorced ☐Widowed ☐Separated

Physician_____ Phone_____ Date of Last Exam_____

Person to contact in case of emergency_____ Phone_____ Relationship_____

Health Information :

Have you ever had any of the following? Please check those apply:

☐AIDS/HIV
☐Anemia
☐Anxiety or excessive stress
☐Allergies_____
☐Arthritis
☐Artificial Joints/ Implants
☐Asthma
☐Back Pain or Sciatica
☐Bell's Palsy
☐Biphosphonates for Bone Loss
☐Birth Control Pills
☐Blood Disease
☐Cancer_____
☐Chemical Sensitivity
☐Chemotherapy
☐Chronic Bronchitis
☐Chronic Fatigue
☐Chronic Headaches
☐Chronic Muscle/Joint Pain
☐Circulatory Problems
☐Cough,persistent or bloody
☐Covid 19
☐Depression
☐Diabetes
☐Difficulty Sleeping
☐Drug Addiction
☐Eye Conditions
☐Emphysema
☐Endocarditis
☐Epilepsy
☐Excessive Bleeding
☐Fainting or dizziness
☐Frequent Sore throats
☐Frequent Urination
☐Glaucoma
☐GI Disorders
☐Hay Fever
☐Headaches
☐Head Injuries
☐Heavy Metal Toxicity
☐Heart Attack
☐Heart Disease
☐Heart Murmur
☐Hepatitis Type_____
☐Herniated Disk
☐Herpes
☐High/Low Blood
☐High/Low Thyroid
☐Hypoglycemia
☐Insomnia
☐Jaundice
☐Jaw Pain
☐Kidney Disorders
☐Low body temperature
☐Lymph Glands swell frequently
☐Palpitations
☐Premedicate
☐Pressure
☐Kidney Disease
☐Liver Disease
☐Lupus
☐Lyme's Disease
☐Mental Disorders
☐Mitral Valve Relapse
☐Multiple Sclerosis
☐Neck Pain
☐Nervous Disorders
☐Numbess fingers and toes
☐Osteoporosis/Osteopenia
☐Pacemaker
☐ Are you Preghant?
Due date:_____
☐Psychiatric/Emotional care
☐Rapid fatigue
☐Radiation Treatment
☐Rheumatic Fever
☐Rheumatism
☐Shaky Hands/Feet
☐Shortness of Breath
☐Short term memory loss
☐Skin Problems
☐Sinus Problems
☐Sleep Apnea
☐Special Diet _____
☐Snoring
☐Stroke
☐Swollen feet or Ankles
☐Swollen Neck Glands
☐Tingling in my body
☐Trouble making decisions
☐Tuberculosis
☐Twitching of Muscles
☐Tumors or growth on head or neck
☐Ulcers
☐Urinary Troubles
☐Venereal Disease (STD)
☐Use Sugar Substitutes
☐Use Tobacco, pipe or cigar smoking
☐Use Recreational Drugs
☐Use Fen Phen
☐Use Hormones
☐Weight Loss,unexplained
☐Work around mercury

Allergies(Please list the response next to each allergy- i.e. rash, hives, anaphylaxis)

☐Acrylic ☐Aspirin ☐Codeine ☐Iodine ☐Latex ☐Local Anesthetic ☐Metal ☐Penicillin ☐Sleeping Pills ☐Sulfa Drugs ☐Others_____

List any medications you are currently taking and the correlating diagnosis:

Medication Name	Dosage	Diagnosis

(if any additional medications please attached a separate page)

Nutritional Supplements:☐None ☐Multivitamins ☐Trace Minerals ☐ EPA-DHA(Omega 3's) ☐Macro-Minerals(Zinc,Magnesium)☐Probiotics ☐Digestive Enzymes ☐AminoAcids ☐Antioxidants ☐Superfoods ☐Others_____

Are you under medical treatment right now?☐Yes ☐No

Have you ever been hospitalized for any surgical operation/serious illness within the last 5 yrs?_____

If yes, please explain _____

Are you wearing contact lenses? ☐Yes ☐No

Women only: a) are you pregnant or think you may be pregnant ☐Yes ☐No

b) Are you nursing? ☐Yes ☐No

c)Are you taking any contraceptives Yes ☐ No☐

Dental Information:

Reason for today's visit_____

Date of last dental visit:_____Date of last X-rays_____Date of Last Hygiene_____

Previous Dentist:_____City/State_____Reason for leaving:_____

Have you ever taken an antibiotic prior to dental treatment? ☐Yes ☐ No

Have you ever had any problem associated with dental anesthetic? ☐Yes ☐No

☐Bad Breath
☐Bleeding Gums
☐Blisters on lips or mouth
☐Burning sensation on tongue
☐Chew on one side of mouth
☐Clicking or popping jaw
☐Dentures or partial
☐Dry mouth
☐Fingernail biting
☐Gum Swollen or tender
☐ Food collection between teeth
☐Grinding Teeth
☐Jaw pain or tiredness
☐Lip or cheek biting
☐Loose teeth or broken fillings
☐Metallic taste
☐Mouth breathing
☐Mouth pain, brushing
☐Nightguard
☐Orthodontic treatment
☐Pain around the ear
☐Periodontal treatment
☐Sensitivity to cold
☐Sensitivity to heat
☐Sensitivity sweets
☐Sensitivity when biting
☐Sores or growths in your mouth
How often do you floss_____
How often do you brush?_____

Is having silver mercury fillings a concern for you? ☐Yes ☐No

Are you accustomed to seeing a dentist on a regular basis ? ☐Yes ☐No

Please rate your comfort level with receiving dental treatment: ☐No problem☐ Slight ☐Moderate

Please describe any problems you have had with past dental experiences _____

Is Biologic Dentistry (using materials that are compatible with your body)an interest to you? ☐Yes ☐ No

Do you believe that the health of the mouth can affect the health of the whole body? ☐Yes ☐ No

DENTAL TREATMENT CONSENT FORM

Patient Name _____ Birthdate _____

Please read and initial the items checked below. Then read and sign the section at the bottom of form.

☐ **1. WORK TO BE DONE**

I understand that I am having the following work done: Fillings_____ Bridges_____ Crowns_____ Extractions _____

Impacted teeth removed_____ General Anesthesia_____ Root Canals_____ Other Xrays, exams

(Initials_____)

☐ **2. DRUGS AND MEDICATIONS**

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

(Initials_____)

☐ **3. 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, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

(Initials_____)

☐ **4. REMOVAL OF TEETH**

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

(Initials_____)

☐ **5. CROWN, BRIDGES AND CAPS**

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation.

(Initials_____)

☐ **6. DENTURES, COMPLETE OR PARTIAL**

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

(Initials_____)

☐ **7. ENDODONTIC TREATMENT (ROOT CANAL)**

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

(Initials_____)

☐ **8. PERIODONTAL LOSS (TISSUE & BONE)**

I understand that I have a serious condition, causing gum and bone infection or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

(Initials_____)

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 to me by anyone regarding the dental treatment that I have requested and authorized for my self or my minor child. I have had full opportunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my satisfaction.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

Patient Agreement to Office Policies

Dr Dollins appreciates your trust and interest in scheduling a new patient exam. We take pleasure in reserving a special amount of time to listen to your specific needs knowing you are wanting the highest quality of care and time to discuss your unique situation.

Financial Agreement

As a condition of your treatment by this office, financial agreements must be made in advance. I understand that all responsibility of payment for the dental work provided in the office for my dependents or myself is mine, due and payable at times services are rendered unless other arrangements have been made. I understand that the fee estimate listed for this dental care can be extended for a period of 6 months from the date of the patient examination. _____I

Insurance Filing

Patients who carry dental insurance understand that all dental service furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help patients by providing treatment information for their insurance forms. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. I understand this facility is not a participating provider of my insurance network and that I will be financially responsible for any additional out-of-pocket costs that may result. I further acknowledge that it is my responsibility to verify my out-of-network benefits with my insurance company and I will not hold Dr Dollins DDS liable for any obscure or omitted contractual language in my insurance contract. _____I.

Returned Checks

I understand that there will be a $35 insufficient funds fee added to my account in the event of a returned check.

Collection Proceedings

In the event my account is turned over to a collection agency for non-payment or other delinquency, I will be responsible for a payment of any collection cost (30%) and /or attorney fees. In addition to the balance owed. Any account turned over to a collection agency forfeits any past special fee and/or discount. Such special fees and /or discounts will be reserved and I will be responsible for payments of regular fee for procedure at the time of service.

Failed Appointments

If I arrive more than **15 minutes late** for my appointment, I may ask to reschedule. Any appointments that are not confirmed in **24 hours** will be removed from our schedule. I understand that my appointment time has been especially reserved for me, and in the event that I need to reschedule, I will give a **72-business hour notice**. Failure to do so will result in cancellation fee of $75/hr. If I am considered a no show for three missed appointments or have excessive cancellations, Dr Dollins' retains the right to dismiss me from the practice. _____I.

Change of Information

I understand that it is my responsibility to advise this office of any change in the information I provide regarding my patient information and health form. _____I.

Acknowledgment of Receipt of Notice of Privacy Practice

I have received a copy of this office's Notice of Privacy Practice. I understand that I have the right to refuse to sign this acknowledgment. _____I.

Patient Dismissal

I understand that there are grounds for immediate dismissal as a patient from Dr Dollins DDS if any offenses are committed; the offenses include, but are not limited to: rude or abusive behavior toward any staff member, non-compliance with treatment plans, medication misuse, multiple missed office visits, failure to pay on the account. _____I.

Email and/or Text Message for Appointment Reminders and Other Healthcare Communications

Patients in this practice may be contacted via email and/or text messaging to remind them of an appointment, to obtain feedback on their experience with the healthcare team, and to provide general health reminders/information. I consent to receiving appointment reminders and other healthcare communications/information through email and/or text _____I.

Pediatric Patients Only

In order for the staff to develop a patient/doctor relationship with your, we ask that you stay in the waiting room during your child's treatment. Children act differently without the parents around and in this way, we can get to know your child better. Don't worry, we will never do a procedure without your consent. WE take a great amount of time explaining everything we do to the child and to you. If you have any questions, don't hesitate to ask, and encourage your child to ask as well. We also take time to work through any fears the child may have of the dentist and our surroundings. That is why we allot as much time as any adult being treated. During the first visit, we talk to the child, answer questions, do a cleaning, take X-Rays (after age 6), and give a complete head, neck, and oral exam. For younger children, we will complete as much as the child will allow us. Afterward, we will bring the parent(s) into the exam room, discuss our findings, treatment plan, and costs, and answer questions. WE will not force your child to do anything against their will. This only encourages fear and dislike of dentists as well as other doctors. Please do not threaten or use "scare tactics" to get your child to cooperate with us. If we absolutely cannot get your child to coorperate, we may refer her/him to a pediatric dentist (a dentist who specializes in child dentistry)._____I.

Dr. D[illegible]ns Biological Dentistry
41377 Margarita Rd. Ste.107
Temecula, CA 92591

Patient-Dentist Arbitration Agreement

Article I.

It is understood that any dispute as to dental malpractice, this, as to whether any dental services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, would 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 or arbitration proceedings. Both parties of this contract by entering into it, have given 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.

Treatment in this office is contingent upon both parties consenting to this Arbitration Agreement.

Article II.

A. Parties to the Agreement:

The term "patient" as used in this agreement includes thundersigned 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 thisagreement includes the undersigned doctor and his or her professional corporation or partnership, and any employees, agents, successors in interest, heirs and assigns of the foregoing individuals or entities and independent contractors. The doctor signing this agreement signs it on behalf of all the foregoing individual and entities, and intends to bind each of them to arbitration to full extent permitted by law.

B. Treatment Covered:

Patient understands and agrees that any dispute of the sort descried in Article I between doctor and patient will be subject to compulsory, binding arbitration.

C. Coverage of Pre-Natal Claims (If Applicable):

Patient understands and agrees that, if doctor treats her during pregnancy, any dispute or sort descried in Article I as to dental treatment rendered to or affecting the unborn child will be subject to compulsory, binding arbitration.

Article III.

A. Informal Resolution of Disputes:

In the event patient feels that a problem has arisen in connection with the 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 or statute of limitations for ninety (90) days.

B. Method of Initiating Arbitration:

If the dispute is not resolved by mutual Agreement within ninety (90) days, patient may initiate arbitration by notifying doctor to that affect. The arbitrator shall be selected by the chief administrator of JAMS ENDISPUTE. The arbitrator must be selected within twenty-one (21) days of the signature on the receipt for a letter sent certified mail return receipt request demanding that a dispute submitted to arbitration. Following the selection of the arbitrator, arbitration must be held within thirty (30) days.

C. Applicable Law:

The arbitration shall be conducted pursuant the California Arbitration Act (C.C.P. 1280-1296). The Arbitrator shall, in addition, have authority to order such other discovery as he/she deemed 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 1975 which shall apply to the same extent as if to dispute or pending before a Superior Court of the State of California.

The arbitrator shall not have the power to commit errors of law or legal reasoning, and the arbitrator's decisiomay be vacated or corrected pursuant the California Code of Civil Procedure Sections 12806.2 or 12086.6 for any such error.

The prevailing party shall be entitled to attorney fees.

Article IV.

A. Revocation:

If you are signing this agreement and then change your mind, the law permits you to revoke the Agreement providing you give your doctor written notice within thirty (30) days of signing that you want to withdraw from the Agreement. However, doctor and patient agree that any claim arising for dental services rendered prior to revocation shall be subjected to arbitration. Furthermore, doctor is not obligated to continue the doctor/patient relationship should you decide to withdraw from the agreement.

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

PATIENT'S NAME: (Please Print): _____ DATE: _____

SIGNED: _____ SIGNED: _____

Patient/Legal Guardian Witness

DOCTOR SIGNATURE _____