Annette Bak Moranda, DDS
40055 Bob Hope Drive, Suite G, Rancho Mirage, CA 92270
Office (760) 321-8003 Fax (760) 321-9584

MEDICAL HISTORY

First: Last:

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____

_____

_____

Do you need to pre-medicate? Yes No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? Yes No
Are you on a special diet? Yes No
Do you use tobacco? Yes No
Do you use controlled substances? Yes No

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain:_____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Renal Dialysis	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Rheumatic Fever	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Rheumatism	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Scarlet Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Shingles	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	Hives or Rash	Yes No	Sickle Cell Disease	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hypoglycemia	Yes No	Sinus Trouble	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Irregular Heartbeat	Yes No	Spina Bifida	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Kidney Problems	Yes No	Stomach/Intestinal Disease	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Leukemia	Yes No	Stroke	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Liver Disease	Yes No	Swelling of Limbs	Yes No
Breathing Problem	Yes No	Frequent Headaches	Yes No	Low Blood Pressure	Yes No	Thyroid Disease	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Lung Disease	Yes No	Tonsillitis	Yes No
Cancer	Yes No	Glaucoma	Yes No	Mitral Valve Prolapse	Yes No	Tuberculosis	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
Congenital Heart Disorder	Yes No	Heart Pace Maker	Yes No	Radiation Treatments	Yes No	Yellow Jaundice	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Recent Weight Loss	Yes No		

Annette Bak Moranda, DDS
40055 Bob Hope Drive, Suite G, Rancho Mirage, CA 92270
Office (760) 321-8003 Fax (760) 321-9584

Have you ever had any serious illness not listed ? ○ Yes ○ No If yes, please explain: _____

_____

_____

Comments: _____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Annette Bak Moranda, DDS
40055 Bob Hope Drive, Suite G, Rancho Mirage, CA 92270
Office (760) 321-8003 Fax (760) 321-9584

PATIENT REGISTRATION

Patient Information:
First Name: _____ Middle Initial:_____
Last Name: _____
Preferred Name:_____
Address: _____
City, _____ State, _____ Zip: _____
Address 2: _____
City, _____ State, _____ Zip: _____
Home Phone: (___)_____ Work Phone: (___)_____Cell Phone: (___)_____
□ I agree to receive text messages from the dental office
Sex: ○ Female ○ Male
Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed
Birth date: _____ Social Security #: _____ Drivers Lic#: _____
E-mail: _____
□ I agree to receive email correspondences from the dental office

Patient's or Parent's/Guardian Employer: _____
Work Phone:(___)_____
IF College Student Name of School: _____
Student Status: ○ Full Time ○ Part Time

Name of Person to contact in an emergency or if unable to reach you:
_____
Phone: (___)_____

Whom may we thank for referring you? _____

Responsible Party: (if someone other than the patient)
First Name: _____ Middle Initial: _____
Last Name: _____
Address: _____
Address 2: _____
Home Phone: (___)_____ Work Phone: (___)_____ Cell Phone:(___)_____
Birth date: _____ Social Security #: _____ Drivers Lic#: _____

X_____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR DATE

Annette Bak Moranda, DDS
40055 Bob Hope Drive, Suite G, Rancho Mirage, CA 92270
Office (760) 321-8003 Fax (760) 321-9584

○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

DENTAL INSURANCE INFORMATION

Primary Insurance Information:

Name of Insured: _____

Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Employer ID: _____ Carrier ID:_____

Insured Social Security #: _____ Insured Birth date: _____

Employer: _____ Insurance Company:_____

Address: _____

City,_____ State,_____ Zip:_____

Address 2: _____

City,_____ State,_____ Zip: _____

Secondary Insurance Information:

Name of Insured: _____

Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Employer ID: _____ Carrier ID:_____

Insured Social Security #: _____ Insured Birth date: _____

Employer: _____ Insurance Company: _____

Address: _____

City,_____ State,_____ Zip: _____

Address 2: _____

City, _____ State, _____ Zip:_____

- Attach a copy of the front and back of your Dental insurance card and ID or Driver's license

X_____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR DATE

GENERAL CONSENT AND INFORMATION FORM

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

RISKS OF DENTAL PROCEDURES IN GENERAL: included (but not limited to) are complications resulting from the use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks and teeth, thrombophlebitis (inflammation to 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 other tissues, referred pain to the ear, neck and head, nausea, vomiting, allergic reactions, itching, bruises, delayed healing, sinus complications, and further surgery. Medication 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 twenty-four hours or until recovered from their effects.

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. 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 the 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 tissues, and understand that risks involved, as well as the possible alternative methods of treatment that have 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 properly guarantee results. I acknowledge that no guarantee or assurance has been make by anyone regarding the treatment, which I am requesting and 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 contract 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 the resolution in lieu of pursuing remedies by way of litigation, in consideration of helping to keep costs of treatment and services as low as possible. I also understand that this agreement is binding on my heirs and all other family members.

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.

Patients Name_____

Signature_____ **Date**_____
(patient / guardian)

CONSENT FORM

Annette Bak Moranda, DDS
40055 Bob Hope Drive, Suite G, Rancho Mirage, CA 92270
Office 760-321-8003 Fax 760-321-9584

Patient Acknowledgment of
Receipt of Dental Materials Fact Sheet and Notice of Privacy Practices

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

* You May Refuse to Sign This Acknowledgment*****

I acknowledge that I have received from this office the following:

1. Notice of Privacy Practices
2. A copy of the Dental Materials Fact Sheet

Print Name: _____

Signature: _____

Date: _____

For Office Use Only

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 acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

Annette Bak Moranda, DDS
40055 Bob Hope Drive, Suite G, Rancho Mirage, CA 92270
Office (760) 321-8003 Fax (760) 321-9584

Authorization for the Release of Dental Records

California

I hereby authorize *Annette Bak Moranda, DDS* to release the information in the dental record of

_____ (patient's name) to

_____
(name of dentist, physician, clinic, or patient's representative)

_____
(address)

Any and all information may be released including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below.

This authorization is effective now and will remain in effect until _____ (date).
I understand that I may receive a copy of this authorization.

_____ _____
Signature Date

If not signed by the patient please indicate relationship:

□ parent or guardian of minor patient

□ guardian or conservator of an incompetent patient

□ beneficiary or personal representative of deceased patient

NOTE: This authorization is intended to comply with applicable state laws. It is not intended as a "Consent" or "Authorization" for the use and disclosure of Protected Health Information (PHI) under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or its implementing regulations. The medical provider to whom this authorization is directed should ensure that he or she is in compliance with applicable HIPAA requirements before releasing the requested records.

CAUTION: If you intend to use the requested information for any purpose other than providing medical treatment, 45 CFR Section 164.502 requires that you make reasonable efforts to limit your request for PHI to the minimum necessary to accomplish the intended purpose of the request.

To be valid, an authorization must be clearly separate from other language on a page and executed by a signature which serves no purpose other than to execute the authorization. It can either be handwritten by the person who signs it or in typeface no smaller than 8 point (this is 8 point).

Place a copy in the patient's chart.

Annette Bak Moranda, DDS
40055 Bob Hope Drive Suite G, Rancho Mirage, CA 92270
Office 760-321-8003 Fax 760-321-9584

Patient Name: _____ Date of Birth: _____

I agree that the dental practice may communicate with me electronically at the email address below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address.

I can withdraw my consent to electronic communications by calling: 760-321-8003

Email Address (PLEASE PRINT CLEARLY):

_____

Patient Signature: _____

Date: _____

Annette Bak Moranda, DDS
40055 Bob Hope Drive, Suite G, Rancho Mirage, CA 92270
Office 760-321-8003 Fax 760-321-9584

Image Release

I hereby give my consent for *Dr. Annette Bak Moranda* to take photographs, slides and/or videotape of _____ (patient's name). I also grant permission to reproduce, print and/or publish these images, in print or electronically, for use in articles, lectures, or advertisements.

I understand that some of these images may be used by laboratories for fabrication of crowns, veneers, bridges, or dentures and these images will become part of my dental record.

I do not expect compensation, financial or otherwise, for the use of these images.

I expressly authorize and grant a license to *Dr. Annette Bak Moranda* her business, organization, employees, or agents for any use of the above-stated images and expressly release and discharge *Dr. Annette Bak Moranda* her business, organization, employees, or agents from any and all potential claims for the use of the above-stated images.

Please initial one:

_____ I consent to the use of my photographs, slides, and/or videotape for articles, lectures, marketing, advertising, and laboratory use.

_____ I consent to the use of my photographs, slides, and/or videotape *ONLY* for laboratory use.

_____ I *DO NOT* consent to the use of my photographs, slides, and/or videotape.

I understand that the information disclosed under this authorization may be subject to disclosure and no longer protected by the federal privacy regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. Finally, I understand that I may revoke this authorization in writing at any time by sending a letter to my dental care provider stating my revocation and the effective date, except to the extent that action has been taken in reliance on this authorization.

I release and discharge *Dr. Annette Bak Moranda* her business, organization, employees or agents from any and all claims or actions I have or may have relating to such use and publication.

_____ _____
Patient's or Legal Guardian's/Representative's Signature Date

_____ _____
Dentist's Signature Date

PLACE A COPY IN THE PATIENT'S CHART.

[AS 11/2012]