RUSSELL CANNON DDS 14150 Culver Drive, Suite 200, Irvine, CA 92604 **949.552.7874**

PATIENT INFORMATION

First Name:______________________ Last Name:____________________

Sex:______ Age:_____Date of Birth:__________Marital Status:__________

Home Phone:______________Work Phone:___________Cell Phone:___________

Home Address:_____________________City:_______State:_____Zip Code:_______

Employment:____

Employer's Name:________________________________Employer's Phone:__________________________

Occupation: _____________________________________Student Status:__________________________

School Name (if a full-time student):_____________________________________Grade:________________

Best places and times to contact you:____

Send appointment reminders via: ☐ Text ☐ Email ☐ Mail

Please tell us where you heard about us:

Was our website a factor in your decision to visit our practice? ○ Yes ○ No

Name of spouse (or Parent, if a minor):______________Spouse/Parent's Employer:___________________

Spouse/Parent Work Phone:_______________________Spouse/Parent Cell Phone:___________________

Other family members treated by us:

Additional Comments:

EMERGENCY CONTACT

Name: ______________________

Relationship to Patient: ____

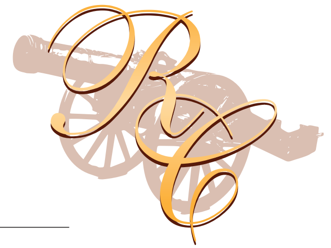
Home Phone: _________________Work Phone:_________________Cell Phone:___________________

Email: ____

Emergency Contact Address:____

City: ____________________State:_________ Zip Code:______________

Person Responsible for Account



First Name: ______________ Last Name: ______________

Relationship to Patient: ______________

Date of Birth: ______ Social Security #: ______________

Driver's Licence #: ________ State: ______ Holder of Insurance: ______

Home Phone: ________ Work Phone: ________ Cell Phone: ________

Email Address: ______________

Billing Address: ______________ City: ______ State: ______ Zip Code: ______

Employment: ______ Employer's Name: ________ Employer's Phone: ______________

Occupation: ______________

Employer's Address: ______________

City: ________ State: ______ Zip Code: ________

Insurance Information

Primary Insurance

Insurance Holder's Name: ______________ Date of Birth: ______________

Relationship to Patient: ______________ Employer: ______________

Member ID: ________ Group ID: ______________

Insurance Company Name: ______________ Insurance Company Phone: ________

Insured's SSN: ______________ Insurance Company's Address: ______________

City: ________ State: ______ Zip Code: ________

Secondary Insurance

Insurance Holder's Name: ______________ Date of Birth: ______________

Relationship to Patient: ______________ Employer: ______________

Member ID: ________ Group ID: ______________

Insurance Company Name: ______________ Insurance Company Phone: ________

Insured's SSN: ______________ Insurance Company's Address: ______________

City: ________ State: ______ Zip Code: ________

Authorization

All of the above information is correct to the best of my knowledge. I authorize use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize Dr. Cannon to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to Dr. Cannon. I permit a copy of this authorization to be used in place of the original. I give Dr. Cannon, its employees, and/or other agents express prior consent to contact me at any/all phone numbers, including cell numbers (by phone call or text message) and email addresses, for the purpose of treatment, insurance, or payment.

Signature: ______________________________ Date: ________

Payment

Does the person responsible for the account already have an account with this office?

○ Yes ○ No

Payment Policies

Thank you for taking the time to understand our payment policies. For any questions about fees, financial policies, or your responsibilities, please ask one of our office staff for clarification.

For Patients with Dental Insurance

We accept dental insurance assignments, with the understanding that any uninsured portion not covered by your insurance plan is to be paid by you at the time of service. As a courtesy, our office will file all applicable insurance forms. Please note that although we strive to provide accurate information, such information is not a guarantee of payment or eligibility with your insurance company and is only an estimate. Your dental insurance plan is a contract between you, your employer, and the insurance company. Depending on your specific insurance plan, your dental insurance may not fully cover our office dental fees for the services we render. The difference between our office dental fees and your insurance reimbursement is your responsibility.

Returned Checks

Personal checks that are returned due to "insufficient funds" are subject to a $25.00 service fee.

Service Charge

Payment is due at each appointment. I agree to pay any outstanding insurance balance within 30 days of the monthly billing date. Please be advised that there is a "Broken Appointment fee" for any missed or broken appointment without 48 hour notice that ranges from $50.00 to $300.00 dependent on the appointment time block and a minimum of 72 hour notice for Monday appointments. To serve all of our patients in a timely manner, we may need to reschedule an appointment if the patient is 15 minutes or more late in arriving to our practice. A "Broken appointment fee" will be assessed. To avoid this charge, kindly give us a minimum of 48 hour notice for any appointment cancellation. Feel free to contact us at any time with questions you may have.

Signature:______________________________ Date:__________

X-Ray/Records Release

There is a fee of $25.00 for any release of X-rays and/or records.

Minors

Adult patients are responsible for full payment at time of service. The adult accompanying a minor is responsible for payment. This office will not bill a non-custodial parent for services delivered to a minor. For unaccompanied minors, treatment may be denied unless charges have been pre-approved to a credit card or other payment arrangements have been made.

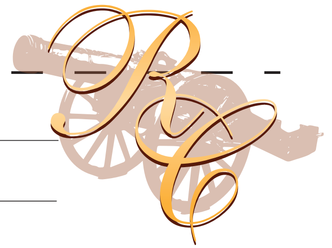
Authorization

Patient Name:______________________________

I hereby authorize payment directly to Dr. Cannon of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of the above-named patient's dental treatment. The information on the page and the dental/medical histories are correct to the best of my knowledge. I grant the right to Dr. Cannon to release the patient's dental and/or medical histories and other information about the patient's dental treatment to third-party payers and/or other health professionals.

Signature:______________________________ Date:__________

Dental History



Previous Dentist

Dentist Name: ______________ Practice Name: ______________ Phone #: ______________

Address: ______________ City: ______________ State: ______ Zip: ______

What did you like about your last dentist?:

What caused you to leave your last dentist?:

Last Dental Visit

Last Dental Visit: ______________ Treatment Complete? ○ Yes ○ No

What was done at your last visit?: ______________

Last X-Rays: ______________ Last Full-Mouth X-Rays: ______________ Last Cleaning: ______________

Dental Hygiene

How often do you visit the dentist?: ______________ How often do you brush your teeth?: ______________

How often do you floss your teeth?: ______________

Please list other dental hygeine aids (Interplak, toothpics, etc.)

Are you interested in regular hygiene cleanings? ○ Yes ○ No

Today's Visit

Do you have any dental problems, pain, or discomfort at this time? If yes, please describe:

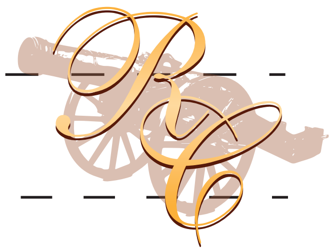
What is the main reason for your visit today?:

- ☐ Tooth Pain
- ☐ Check Up
- ☐ Cleaning
- ☐ Whitening
- ☐ Cosmetic Dentistry
- ☐ Restorative Dentistry
- ☐ Other:

What would you like to learn more about?

- ☐ Whitening
- ☐ Cosmetic Dentistry
- ☐ Implants
- ☐ Bridges
- ☐ Veneers
- ☐ Dentures
- ☐ Partial Denture
- ☐ Prevention
- ☐ Other:

Dental History



Dental Concerns

Check all that apply

Teeth

- ☐ Broken/Chipped
- ☐ Difficulty Chewing
- ☐ Loose Teeth
- ☐ Grinding or Clenching
- ☐ Sensitive to Cold
- ☐ Sensitive to Sweets
- ☐ Bad Taste in Mouth
- ☐ Crooked
- ☐ Discolored
- ☐ Tooth Pain
- ☐ Missing Teeth
- ☐ Sensitive to Heat
- ☐ Blisters on Lips/Mouth
- ☐ Others:
- ☐ Decay
- ☐ Loose/Missing Filling
- ☐ Food Trap Areas
- ☐ Mouth Sores
- ☐ Sensitive to Biting
- ☐ Orthodontic Treatment

Gums

- ☐ Bad Breath
- ☐ Bleeding
- ☐ Receding
- ☐ Red (Discolored)
- ☐ Sore
- ☐ Periodontal Treatment
- ☐ Abcessed
- ☐ Swollen
- ☐ Other:

Facial/Jaw Pain

- ☐ Frequent Headaches
- ☐ Pain in Temples
- ☐ Head Injury
- ☐ TMJ Pain
- ☐ Avoid Certain Foods
- ☐ Jaw Locks Open/Closed
- ☐ Neck Injury
- ☐ Other:
- ☐ Popping/Clicking
- ☐ Jaw Injury
- ☐ Pain Around Ear

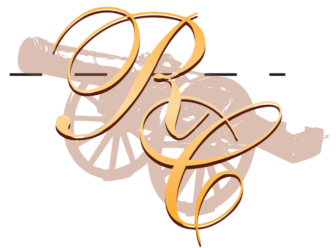
Other Concerns

- ☐ Smoking/Dipping
- ☐ Wisdom Teeth
- ☐ Limited Orthodontics
- ☐ Fractured Tooth Syndrome
- ☐ Stain
- ☐ Teeth Straightening
- ☐ Wisdom Teeth Extraction
- ☐ Dental Phobias
- ☐ Biting Cheeks or Lip
- ☐ Nail Biting
- ☐ Burning Tongue
- ☐ CPAP
- ☐ Chew on One Side
- ☐ Retainer
- ☐ Cosmetics
- ☐ Other:
- ☐ Fillings
- ☐ Sleep Apnea
- ☐ Tooth Replacement
- ☐ Implants
- ☐ Snoring
- ☐ Dry Mouth
- ☐ Smile Makeover

Does food tend to get caught between your teeth? If yes, where?:

Do you hold foreign objects (pencils, pipe, pins, nails, fingernails, etc.) wtih your teeth? If yes, what?:

Dental History



Have you ever had-

Check all that apply

- ☐ Orthodontic Treatment
- ☐ A Bite Plate or Mouth Guard
- ☐ Periodontal Treatment
- ☐ Other:
- ☐ Oral Surgery
- ☐ Any canker sores or cold sores on your lips, tonge, gums, or body

A serious injury to the mouth or head? if yes, please describe including cause:

Ratings-

☐ On a scale of 1-5 (1 bad, 5 good), please rate how you feel your overall dental health is.

☐ On a scale of 1-5 (1 bad, 5 faithful), over the last ten years, rate how faithfully you have had your teeth cleaned.

☐ On a scale of 1-5 (1 not sensitive, 5 very sensitive), what is your level of sensitivity to dental procedures?

☐ On a scale of 1-5 (1 not sensitive, 5 very sensitive), what is your sensitivity to dental cleaning appointments?

☐ On a scale of 1-5 (1 unhappy, 5 very happy), rate how you feel about the look of your smile.

☐ On a scale of 1-5 (1 poor, 5 great), how do you rate your quality of sleep?

☐ On a scale of 1-5 (1 low, 5 high), if you snore, how would you rate the severity of your snoring?

Miscellaneous-

Has fear ever been an issue for you in a dental office? ○ Yes ○ No

Has time ever been a factor in getting your dental work done? ○ Yes ○ No

Has the cost of dental treatment been a concern for you? ○ Yes ○ No

If yes, how can we help?:

Tell us about your good dental experience/visits:

Tell us about your bad dental Experiences/visits:

What do you like most about your teeth/smile?:

Is there anything you don't like about your teeth/smile?:

Dental History

Miscellaneous Continued

Is there anything you would like to change about your smile?:

What are your long-term goals? How would you like your teeth to feel and look?:

What are your short-term dental goals?:

Do you have any upcoming event or circumstances (such as weddings, major surgeries, etc.) we should/need to know about? If yes, what and when?:

Is there anything else you feel we should know?:

Medical History

How is your general health? ○ Good ○ Fair ○ Poor

Are you currently under medical treatment? if yes, what for?:

Do you require antibiotic pre-medication for your dental work? If yes, what for?:

Physician's Name:____________________

Phone: __________ Last visit:__________

Home address:__________ City:________ State:_____ Zip: _____

Do we have permission to contact your doctor regarding your care? ○ Yes ○ No

Have you ever had

Check all that apply

- ☐ Arthritis
- ☐ Cancer/Chemotherapy
- ☐ Heart Murmur/Trouble
- ☐ Numbness of arms or hands
- ☐ Asthma
- ☐ Endocrine Problems
- ☐ Hypertension (High blood pressure)
- ☐ Shortness of Breath
- ☐ Arteriosclerosis
- ☐ Emotional Problems
- ☐ History of Substance Abuse/Drug Addiction
- ☐ Swollen/Painful joints
- ☐ Blood Disease
- ☐ Intestinal Disorders
- ☐ Liver Problems
- ☐ Anemia

Medical History

- ☐ Dizziness
- ☐ Fainting
- ☐ Hypotension (Low blood pressure)
- ☐ Heart Attack/Stroke
- ☐ Artificial Valves
- ☐ Artifical Bones/Joints
- ☐ Blood Transfusion
- ☐ Severe/Frequent Headaches
- ☐ Tuberculosis
- ☐ Abnormal Bleeding
- ☐ Hospitalized for any reason
- ☐ Thyroid Disease
- ☐ Gout
- ☐ Congenital Heart Lesion
- ☐ Herpes
- ☐ Hay fever
- ☐ Hypoglycemia
- ☐ Osteoporosis
- ☐ Recent weight loss
- ☐ Sexually transmitted disease
- ☐ Tattoos/body piercing
- ☐ Yellow jaundice
- ☐ Latex sensitivity
- ☐ Swollen neck glands
- ☐ Easily winded
- ☐ Frequent diarrhea
- ☐ Spina bifida
- ☐ Epilepsy
- ☐ Hearing Disorders
- ☐ Nervous Disorder
- ☐ Heart Surgery
- ☐ Congenital Heart Defect
- ☐ Shingles
- ☐ Fever Blisters
- ☐ Radiation Treatments
- ☐ Venereal Disease
- ☐ Ulcers
- ☐ Emphysema
- ☐ Angina
- ☐ Chest Pain
- ☐ Cortisone Medicine
- ☐ Leukemia
- ☐ Heart disease
- ☐ Irregular heartbeat
- ☐ Pain in jaw joints
- ☐ Rheumatism
- ☐ Sickle cell anemia
- ☐ Allergies
- ☐ Seizures
- ☐ Smoker
- ☐ Tonsillitis
- ☐ Anaphylaxis
- ☐ Genital herpes
- ☐ Birth Defects
- ☐ Head Injury
- ☐ Kidney Problems
- ☐ TMD/TMJ (jaw pain)
- ☐ Diabetes
- ☐ Hepatitis A, B, or C
- ☐ Pneumonia
- ☐ Bruise Easily
- ☐ Chronic fatigue syndrome
- ☐ High/Low Blood Sugar
- ☐ Rheumatic Fever
- ☐ Pacemaker
- ☐ Mitral Valve Prolapse
- ☐ HIV/AIDS
- ☐ Sinus Problems
- ☐ Psychiatric Problems
- ☐ Hemophilia
- ☐ Difficulty Breathing
- ☐ Glaucoma
- ☐ Artificial Hip/Joint
- ☐ Circulatory Problems
- ☐ Convulsions
- ☐ Excessive Thirst
- ☐ Hives/skin rash
- ☐ Lung disease
- ☐ Parathyroid disease
- ☐ Scarlet fever
- ☐ Sinus trouble
- ☐ X-ray or cobalt treatment
- ☐ Cough-persistent or bloody
- ☐ Swelling of feet/ankles
- ☐ Tumor or growth on head/neck
- ☐ Alzheimer's disease
- ☐ Renal dialysis
- ☐ Other:

Medical History

Have you ever had an adverse reaction or allergies to any medication or substance?

Check all that apply

- ☐ Acrylic
- ☐ Codeine
- ☐ Iodine
- ☐ Nitrous Oxide
- ☐ Sedatives
- ☐ Valium
- ☐ Aspirin
- ☐ Dental Anesthetics
- ☐ Latex
- ☐ Articaine
- ☐ Sulfa Drugs
- ☐ Xylocaine
- ☐ Barbiturates
- ☐ Erythromycin
- ☐ Metals
- ☐ Penicillin
- ☐ Tetracycline
- ☐ Other:

Are you being/have you ever been treated for cancer of any kind? If yes, please explain:

Are you currently taking or have you ever taken any bisphosphonate drugs? These include: alendronate (Fosamax), clodronate (Ostac, Bonefos), etidronate (Didronel), ibandronate (Boniva), pamidronate (Aredia), risedronate (Actonel), tiludronate (Skelid), zoledronic acid (Zometa). ○ Yes ○ No

Do you take or have you taken Phen-Fen or Redux? ○ Yes ○ No

Do you smoke or chew tobacco? ○ Yes ○ No

Do you use alcohol, cocaine, or other drugs? ○ Yes ○ No

Do you wear contact lenses? ○ Yes ○ No

Are you on a special diet? ○ Yes ○ No

Have you lost or gained more than 10 pounds in the past year? ○ Yes ○ No

Do you use more than two pillows to sleep? ○ Yes ○ No

Have you been treated in a hospital in the last five years? ○ Yes ○ No

If female, please select if you are:

Please list all current prescriptions:

Please list any other serious medical conditions, impending operations, or other medical/dental information that may possible affect your dental treatment:

Do you wish to talk to the dentist privately about any problems/concerns? ○ Yes ○ No

All of the above information is correct to the best of my knowledge. 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. I understand that the above information is necessary to provide me with dental care in an efficient and safe manner. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release information to you.

Signature:______________________________ Date:______________

Medical History

What do you already know about our office and what are your expectations?:

What would it take for you to trust us to be your dentist?:

We can look at your mouth from 3 different perspectives. This will help us determine how to best treat you and your specific dental needs. What combination of these would you like us to use for your situation?

- ☐ As a general dentist
- ☐ As a cosmetic dentist
- ☐ As a functional (bite, TMJ) dentist

At what point do you want us to initiate treatment for you?

- ☐ When something isn't ideal
- ☐ When something worsens
- ☐ When my tooth hurts or breaks

HIPAA practices of acknowledgement

We are required by the Health Insurance Portability and Accountability Act (HIPAA) to both offer our patients a copy of our Notice of Privacy Practices and to obtain your signature that we did offer you this document.

A copy of our Notice of Privacy Practices is available to you and is displayed at all times in our reception area.

This acknowledgement will be kept in your dental file. If you would like a copy, please feel free to request one at any time.

Thank you.

Signature:______________________________ Date:__________

If signing on behalf of someone, explain your relationship to the patient:

Doctor's Comments:

____

____

____

Doctor's Signature ______________ Date ______________

Financial and Dental Insurance Policy

We are committed to providing you with the best possible dental care. If you have medical and dental insurance, we will gladly help you receive your maximum allowable benefits, thus minimizing your costs. In order to achieve these goals, we need your assistance and understanding of our policy.

Payment for services is due at the time they are rendered unless payment arrangements have been made in advance in written form. We accept cash, check, Visa, MasterCard, Discover, American Express, CareCredit and Springstone. In order to keep our operating costs and ultimately your costs down, we generally do not bill patients. As a courtesy to you, we will file your insurance claim for you. In order to process your claim, we just have complete insurance information.

Returned checks will be charged a $25.00 fee upon notification to us by the bank, and we may require alternative means of future payments. You are responsible for all reasonable collection cost and attorney fees in the event of any default of balance owed.

When you make an appointment with us, please remember that this time has been reserved for you. A charge of $50.00 will be made for every half hour of your scheduled appointment time for broken or cancelled appointments without 48 hours notice.

We will gladly discuss your proposed treatment and answer any questions relating to your account. We will not perform any procedure without your knowing the cost of the treatment up front.

As far as your insurance is concerned, please understand the following:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are usually covered up to the allowance determined by each carrier. This does not apply to companies who reimburse based on an arbitrary "schedule of fees" which bears no relationship to the current standard and cost of care in this area.
3. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We do not render our services on the basis that insurance companies will accept or pay all of our fees. Proposed treatment plans are based on services needed.
4. Estimate of co-pays are based on information available at that time. Insurance carriers do not guarantee benefits until claim is processed.
5. If your insurance fails to pay the portion which they are supposed to cover, you are ultimately responsible for the balance due.

WE must emphasize that as dental care providers, our relationship is with YOU, not your insurance company. While the filing of insurance is a courtesy that we extend to our patients. ALL charges are your responsibility from the date services are rendered. If questions or concerns arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or uncertainty regarding insurance coverage, please do not hesitate to ask us.
We are here to help you.

Sincerely,
Dr. Russell Cannon and Staff

I HAVE READ THE ABOVE CONDITIONS AND AGREE TO THEIR CONTENT

Signature:______________________________ Date:__________

Questionnaire for snoring

Epworth Sleepiness Scale Form

How likely are you to doze off or fall asleep in the situations described in the box below, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

0= Would never doze
1= Slight chance of dozing
2= Moderate chance of dozing
3= High chance of dozing

Situation Chance of Dozing

Sitting and Reading: ____________________

Watching T.V.: ____________________

Sitting, inactive in a car for an hour without a break: ____________________

Lying down to rest in the afternoon when circumstances permit: ____________________

Sitting and talking to someone: ____________________

Sitting quietly after a lunch without Alcohol: ____________________

In a car, while stopped for a few minutes in traffic: ____________________

Total Score: ____________________

Behavior During Sleep

0= Never during a usual night
1= Less than once a week
2= Once to about half the nights per week
3= Half the nights to almost always
4= Almost always or every night
?= Don't know or haven't been told

During your usual sleep, you have noticed or have been told, you do the following:

Snore Loudly: ____________________

Stop Breathing: ____________________

Questionnaire for snoring

Choke, struggle for breath:________________________

Toss and turn frequently:________________________

Wake up with headache:________________________

Usual number hours of sleep per night:________________________

Number of time you rise to use toilet:________________________

Have you had an overnight sleep test:________________________

What other doctors have you seen about your snoring, and what did they advise or do?:

Signature:____Date:______________

Doctor's Comments:

____

____

____

____

Doctor's Signature ______________________ Date ______________________

Medical Insurance Name: (Circle)

PPO HMO Medicare Kaiser

Local Anesthetic Consent Form

Our office routinely uses local anesthetics to aid in the administration of quality pain-free dental care. Although local anesthesia is extremely safe from a statistical standpoint, complications from the administration of local anesthetic are possible.

Potential common complications include, but are not limited to, pain, swelling and bruising. Rare but more serious potential complications include, but are not limited to, permanent numbness or abnormal sensation as well as life-threatening reactions.

By signing this consent, patient understands the provisions of informed consent as described and has no further questions.

Patient Name (Print): ____

Parent or Guardian Name: ____
*If patient is younger than 18.

Signature:____Date:____________