Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible care
To help us meet all your dental healthcare needs,
please fill out this form completely in ink.
If you have any questions or need assistance,
please ask us - we will be happy to help.

Patient Information (Confidential)

Today's date _____

Name_____ Birthdate_____ Social Security _____

Address _____ City _____ Zip code _____

Phone number _____ Email _____

Patient employer _____

Check Appropriate Box : ❒ Minor ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated

Emergency contact _____ Relation_____ Phone number_____

Whom may we thank for referring you to our office? _____

If Student, Name of School/ College	If Minor, Parent / Guardian Name
_____	_____
City _____ State _____	Employer _____
❒ Part time ❒ Full time	Phone number _____

Responsible Party (for minors)

Name _____ Relationship _____ Phone number _____

Address (if different from above) _____ City _____ State _____ Zip Code _____

Insurance *required

I have dual insurance ❒ YES ❒ NO

*Primary Insurance Company _____	*Secondary Insurance Company _____
Insurance phone number _____	Insurance phone number _____
*Subscriber employer_____	*Subscriber employer_____
*Subscriber name _____	*Subscriber name _____
*Birth Date ____/____/____ *Social Security #_____	*Birth Date ____/____/____ *Social Security #_____
*Insurance ID# _____ Group # _____	*Insurance ID# _____ Group # _____
Relation to subscriber _____	Relation to subscriber _____

PATIENT MEDICAL HISTORY	Y	N
Are you now under the care of a physician? If, Yes: Physician Name: _____ Phone:_____	☐	☐
Are you in good health? If no, explain_____	☐	☐
Has there been any change in your general health within the past year? If yes, what condition is being treated?	☐	☐
Have you had a serious illness, operation or been hospitalized in the past 5 years? If yes, what was the illness or problem? _____	☐	☐
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If yes, explain _____ _____	☐	☐
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax® , Actonel® , Atelvia, Boniva® , Reclast, Prolia) for osteoporosis or Paget's disease? If yes, what medication _____	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia® , Zometa® , XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Date Treatment began: _____	☐	☐

Please mark all that apply below

High blood pressure ☐	**Angina** ☐	**Kidney Diseases** ☐	**Hay Fever / Allergies** ☐
Heart Attack ☐	**Stroke** ☐	**AIDS or HIV infection** ☐	**Tuberculosis** ☐
Rheumatic Fever ☐	**Anemia** ☐	**Sexually Transmitted Disease** ☐	**Radiation Therapy** ☐
Swollen Ankles ☐	**Emphysema** ☐	**Thyroid Problem** ☐	**Glaucoma** ☐
Fainting / Seizures ☐	**Cancer** ☐	**Heart Disease** ☐	**Recent Weight Loss** ☐
Asthma ☐	**Arthritis** ☐	**Cardiac Pacemaker** ☐	**Liver Disease** ☐
Low Blood Pressure ☐	**Hepatitis / Jaundice** ☐	**Heart Murmur** ☐	**Respiratory Problems** ☐
Epilepsy / Convulsions ☐	**Stomach Troubles/ Ulcers** ☐	**Heart Trouble** ☐	**Anemia** ☐
Leukemia ☐	**Chest Pains** ☐	**Mitral Valve Prolapse** ☐	**Eating Disorder** ☐
Diabetes ☐	**Easily Winded** ☐	**Frequently Tired** ☐	**Other** ☐

Do you have any disease, condition, or problem not listed above that you think I should know about?
If yes, explain

_____

_____

Do you wear contact lenses? Yes ❒ No ❒

Do you use controlled substances (drugs)? Yes ❒ No ❒
If yes, explain_____

Do you use tobacco?
Yes ❒ **What kind?**_____ No ❒

Are you taking or have you recently taken any prescription or over the counter medicine(s)? If yes, please list _____

_____

_____

Medications list continued:

_____

_____

_____

_____

_____

Mark all that apply below

Women Only

Taking birth control Yes ❒ No ❒

Taking hormone medication Yes ❒ No ❒

Pregnant Yes❒ No ❒

# of Months _____ **Weeks** _____

Nursing Yes ❒ No ❒

Allergy to any of the following (mark all that apply)

Local anesthetics	❒
Aspirin	❒
Penicillin or other antibiotics	❒
Barbiturates	❒
sedatives	❒
Sulfa drugs	❒
Codeine or other narcotics	❒
Metals	❒
Latex (rubber)	❒
Iodine	❒
Food	❒
Other _____	❒

Dental History

	Y	N
Date of your last dental exam _____ **Date of last dental x-rays**_____		
Do your gums bleed while brushing or flossing?	❒	❒
Do you have any clicking, popping or discomfort in the jaw?	❒	❒
Do you brux or grind your teeth?	❒	❒
Do you have sores or ulcers in your mouth?	❒	❒
Do you wear dentures or partials?	❒	❒
Have you ever had a serious injury to your head or mouth?	❒	❒
Do you have any teeth sensitive to sweet or sour liquids/foods?	❒	❒
Do you feel pain in any of your teeth?	❒	❒
Do you have dental anxiety? **If yes, is it** ❒ Mild ❒ Moderate ❒ Severe	❒	❒

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian _____ **Date** _____

Signature of Dentist _____ **Date**_____

Dimitri Grammas D.D.S.

149 E. Lincoln Ave Orange, CA 92865

Financial Policy Agreement

• **Insurance and Patient Copay** Based on your plan benefits provided by your insurance plan, there may be a copay and deductible. These costs are due at the time of your visit. A claim will be submitted to your insurance company and may take 30-60 days to process. Insurance coverage is never a guarantee of payment. In the event the treatment is not covered the patient is responsible for the cost.

• **Billing and remaining balances** Copayments are an estimate based on current insurance benefits and maximums listed by the insurance company at the time of your visit. In the event the insurance payment is greater or lesser than expected, the balance is adjusted and the patient will receive a statement or refund for the difference.

• **Self-Pay** If you do not have insurance coverage, payment for your service is collected at the time of your visit. For your convenience, if you require a payment plan, we accept Care Credit. An application can be completed at www.carecredit.com. We accept cash, checks and all major credit cards as well as HSA and FSA cards. Limitations set by the FSA and HSA accounts are the patient's responsibility. Please ensure your savings cards will cover the treatment prior to your appointment. We are not responsible for refunds requested by your health savings accounts.

• **Patient responsibility and Lab Charges** With treatment that requires lab work, It is the patient's responsibility to return to complete treatment in the time required. Delaying completion of treatment may result in additional lab costs. The patient will be responsible for these additional costs.

• **Missed and Broken Appointments** We kindly ask that you notify our office at least 24 hours prior to your visit if you are unable to make it. Broken appointments are subject to a **$65.00 fee per patient** scheduled.

• **Late Appointments** Due to the capacity limitations, we are unable to accommodate late appointments. If you will be more than 10 minutes late to your appointment, please contact our office to reschedule.

I have read and understand the above statements.
By signing, I agree to the terms of this Financial Policy Agreement for the office of Jim Grammas, D.D.S.

Patient's Name_____ **Parent's name (If minor)**_____

Signature_____ **Date**_____

❒ **Parent** ❒ **Legal Guardian** ❒ **Self**

General Dentistry Informed Consent Form

DIMITRI GRAMMAS D.D.S • 149 E. LINCOLN AVE. • ORANGE, CA 92865

*******PLEASE INITIAL: EXAM, X-RAY & TREATMENT PLAN AT FIRST VISIT.***

• Examination and X-Rays(initial)____

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan.

•Treatment Plan (initial) ____

I understand the recommended treatment and my financial responsibility as explained to me. I understand that by signing this consent I am in no way obligated to any treatment. I also acknowledge 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.

*******INITIAL AS NEEDED:***

•Drugs and Medications (initial) ____

I understand that antibiotics, analgesics and other medications can cause allergic reactions such as redness and swelling tissue, pain, itching,vomiting and/or anaphylactic shock.

•Fillings (initial) ____

I understand that care must be exercised in chewing on filling teeth, especially during the first 24 hours to avoid breakage. I understand that a more extensive restorative procedure than originally diagnosed may be required due to additional or extensive decays I understand that significant sensitivity is a common after effect of newly placed fillings.

•Crowns, Bridges, Veneers (initial) ____

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 come off easily and that I must be careful to ensure that they are kept on until the permanent crown is delivered. I realize the final opportunity to make changes (shape of, fit, size and color) will be before cementation. It is also my responsibility to return for permanent cementation within 20 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown or bridge. I understand there will be additional charges for remakes due to my delaying permanent cementation.

•Extractions (initial) ____ Tooth #:_____ Date:_____ / Tooth #:_____ Date:_____

Alternatives to removal of teeth have been explained to me (If applicable: root canal therapy, crown and bridge procedures, periodontal therapy, etc.) I understand removing teeth does not always remove the infection, if present, and 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, or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.

•Periodontal Disease (initial) ____

I understand that I have been diagnosed with a serious condition, causing gum and bone inflammation and/or loss and that the result could lead to the loss of teeth. Alternative treatments have been explained to me, including gum surgery, tooth extraction and/or replacement.

•Partials and Dentures (initial) ____

I understand the wearing of partials/dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate dentures (placement of dentures immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed at a later date. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of my partial/denture. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of more than 30 days, additional charges could be incurred.

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 made by anyone regarding the dental treatment, which I have requested and authorized.

By signing this document, I agree that I have read and understand the consent to the above procedures if needed.

Patient Signature_____ Date_____

Dentist Signature:_____ Date_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

&

Dental Materials Fact Sheet Acknowledgement

Dimitri Grammas D.D.S 149 E. Lincoln Ave. Orange, CA 92865

PATIENT NAME _____

I understand that I can obtain a copy of the NOTICE OF PRIVACY PRACTICES at www.dhcs.ca.gov

I understand that my treatment plan may require multiple Doctors, Dentists and Specialists that require my dental health, medical health and insurance information be shared with these specialists in order to provide accurate and safe treatment.

PLEASE MARK AN OPTION BELOW

With whom may we share your dental health, treatments and concerns?

❒ **I prefer not to share my dental health with my spouse / partner / other relative**

❒ **Please share with person(s) listed below**

Name _____ **Relationship** _____

Signature _____ **Date** _____

Dental Materials Fact Sheet

I understand that I can obtain a copy of this office's Dental Materials Fact Sheet at https://www.dbc.ca.gov

Signature _____ **Date** _____

For Office Use Only

Individual refused to sign Communications barriers prohibited obtaining acknowledgment An emergency situation prevented us from obtaining acknowledgement Other (Please Specify):

_____