Thank you for selecting our office and allowing us the opportunity to meet with you. We take pride in our ability to provide you with the highest quality dental treatment, latest products and techniques in a warm and caring environment. We design treatment plans to meet our patient’s individual needs.

We have only one treating doctor at our facility. Dr. Burton will always be the doctor that examines and treats you. Our staff consists of six people:

Cheryl & Ashley can assist you in the front office

Debbie & Judy are our dental assistants

Caity & Nikki are our registered dental hygienists

Your new patient visit may include the following; a comprehensive examination, a professional cleaning and any necessary diagnostic films, photographs or study models to properly diagnose and plan for your lifelong oral health and comfort.

Please bring the attached forms with you to your appointment so that we will be better prepared to meet with you. Also included are the directions to our office – please do not hesitate to call if you have any questions. Feel free to visit our web site www.OaksSmile.com for more information regarding our practice.

Sincerely,

*Dr. Burton, Cheryl, Ashley, Debbie, Judy, Caity & Nikki*

Today’s Date: 

Mr.  Mrs.  Ms.  Dr.  Male  Female

Single  Married  Divorced  Widowed

Name:  

Last First

Birthday: // Age:  SSN: -  - 

Driver’s License:  Email Address: 

Home Address: 

Street City State Zip

Home/Cell Number: ()-  Work Number: ()  -  Ext: 

Employer:  Occupation: 

How did you hear about us? Internet  BNI  Referral  Other

Referred by: 

Other family members seen by us: 

**Emergency Contact Information:**

Name:  Relationship: 

Phone Number: ()  - 

**Dental Insurance Information:**

*Please give your card to the front desk to make a copy of as well as your Driver’s License.*

Insurance Company:  Phone Number: () - 

Subscriber’s Name:  Subscriber’s Birthday: //

ID Number/SSN:  Group Number: 

Relationship:  Employer: 

** (Initial)** I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

**Dental History**

Previous/Current Dentist: Date of last visit: 

Why have you come to the dentist today? 

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Yes | No |  | Yes | No |
| Are you currently in pain |  |  | Have you ever had periodontal disease? |  |  |
| Do you floss daily |  |  | Do you have loose teeth |  |  |
| Do you brush daily |  |  | Do you clench or grind your teeth |  |  |
| Do your gums ever bleed |  |  | Have you had any orthodontic work |  |  |
| Do your gums ever itch |  |  |  |  |  |

Your current dental health is: Good  Fair  Poor

Are your teeth sensitive to: Heat  Cold  Chewing

Have you ever had any serious complications with prior dental treatments? Yes  No

Do you need to pre-medicate before dental appointments? Yes  No

Are you satisfied with the appearance of your teeth? Yes  No

-If No, what would you like to change? Length  Shade  Spaces  Crowding

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Have you experienced any of the following? |  |  |  |  |  |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | Yes | No |  | Yes | No | | Clicking |  |  | Difficulty Opening |  |  | | Pain |  |  | Difficulty Closing |  |  | |  |  |  |  |  |

**Sleep**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Yes | No |  | Yes | No |
| Do you snore |  |  | Have you been diagnosed with sleep apnea |  |  |
| Have you been told you snore |  |  | Do you have a CPAP Machine |  |  |
| Have you ever had a sleep apnea test |  |  | Do you have an Oral Appliance |  |  |

**Medical History**

Physician’s Name:  Phone Number: () - 

Current Health: Good  Fair  Poor

Do you smoke tobacco in any form? Yes  No

Have you ever taken Phen-Fen, Redux or Pondimin? Yes  No

Have you ever taken bisphosphonates? (i.e. Boniva, Actonel, Fosamax) Yes No

If yes, IV  or Oral

*For Women*: Are you pregnant? Yes  No  Unsure  Week:

Are you nursing? Yes  No

**Do you or have you experienced the following?**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Yes | No |  | Yes | No |  | Yes | No |
| Abnormal Bleeding |  |  | Emphysema |  |  | Lupus |  |  |
| Alcohol Abuse |  |  | Epilepsy |  |  | Mitral Valve Prolapse |  |  |
| Anemia |  |  | Fainting Spells |  |  | Pacemaker |  |  |
| Anxiety |  |  | Glaucoma |  |  | Persistent Cough |  |  |
| Arthritis |  |  | Hay Fever |  |  | Psychiatric Problems |  |  |
| Artificial Bones/Joints |  |  | Headaches |  |  | Radiation Treatment |  |  |
| Artificial Valves |  |  | Heart Attack |  |  | Rheumatic Fever |  |  |
| Asthma |  |  | Heart Murmur |  |  | Seizures |  |  |
| Blood Transfusion |  |  | Heart Surgery |  |  | Shingles |  |  |
| Cancer |  |  | Hemophilia |  |  | Sickle Cell Disease |  |  |
| Chemotherapy |  |  | Hepatitis |  |  | Sinus Problems |  |  |
| Chicken Pox |  |  | Herpes |  |  | Steroid Therapy |  |  |
| Colitis |  |  | High Blood Pressure |  |  | Stroke |  |  |
| Congenital Heart Defect |  |  | High Cholesterol |  |  | Thyroid Problems |  |  |
| Depression |  |  | HIV+/AIDS |  |  | Tuberculosis (TB) |  |  |
| Diabetes |  |  | Kidney Problems |  |  | Ulcers |  |  |
| Difficulty Breathing |  |  | Liver Disease |  |  | Venereal Disease |  |  |
| Drug Abuse |  |  | Low Blood Pressure |  |  |  |  |  |

Have you had any recent surgeries? Yes No  (If yes please list) 



**Are you allergic to the following?**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Yes | No |  | Yes | No |  | Yes | No |
| Aspirin |  |  | Erythromycin |  |  | Sedatives |  |  |
| Barbiturates |  |  | Jewelry/Metals |  |  | Sulfa Drugs |  |  |
| Codeine |  |  | Latex |  |  | Tetracycline |  |  |
| Dental Anesthetics |  |  | Penicillin |  |  | Other |  |  |

Please list any other allergic reactions: 



**Prescribed Medications**

(If you are taking more than 3 medications, please use our continued medication form)

Drug Name:  Purpose: Strength: 

Drug Name:  Purpose: Strength: 

Drug Name:  Purpose: Strength: 

**Consents:**

I have read, and I understand both the Notice of Privacy Practices and the Dental Materials Fact Sheet.

Signature:  Date: 

E-mail and text message appointment reminders: sent three weeks & two days before, and the day of your appointment. If you opt in you are authorizing Demand Force to send these reminders to you.

***\*If left blank you will be automatically opted in\****

Text messages: Opt In  Opt Out  E-mail: Opt In  Opt Out

**Authorization:**

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I understand that I am responsible for payment of services rendered. As a courtesy, we will file your dental insurance as an out of network provider, so you may receive reimbursement. I have received a copy of this office’s Notice of Privacy Practices. We use this information to provide you with excellent treatment. We may disclose Patient Health Information (PHI) to third parties that perform services for Rodney P. Burton, DDS in the administration of your benefits in accordance with HIPAA. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate that performs services for Rodney P. Burton, DDS in the administration of your benefits. Our affiliates do not sell, share or rent our users' personally identifiable information unless required by law, do not send any e-mail or other communications without user permission, and do not send spam.

Signature:  Date: 

Reviewed:  Date: 

HIPAA Consent to Share Dental Information

I, authorize, Dr. Rodney P. Burton, DDS,

(Print your name)

to share the below indicated information to the following person(s):

Name:  Relationship: 

Name:  Relationship: 

Name:  Relationship: 

Please indicate the information that we may share:

() Making appointments ()Account or Financial Information

()Confirming appointments ()Make payments

()Discussing treatment needed and/or preformed ()Insurance information/benefits

\*This consent will remain valid from here forward unless otherwise informed by the patient and a new form is filled out\*

Signature:  Date: 

**If you do not authorize to have your information shared with anyone please fill out below:**

I  *do not* authorize to have my

(Print your name)

information shared with anyone, including my spouse, or any other family member or guardian please sign and date below:

\*This consent will remain valid from here forward unless otherwise informed by the patient and a new form is filled out\*

Signature:  Date: 

For office use only:

Witness:  Date: 

Directions to our Office

From 101 South

Exit Moorpark Road

Turn left onto Moorpark Road

Turn right onto Thousand Oaks Blvd

Turn right onto Baker Ave/Lombard Street (Wells Fargo is on the corner)

Our office will be located on the right-hand side, 228 Lombard St., Suite C

From 101 North

Exit Moorpark Road

Turn right onto Moorpark Road

Turn right onto Thousand Oaks Blvd

Turn right onto Baker Ave/Lombard Street (Wells Fargo is on the corner)

Our office will be located on the right-hand side, 228 Lombard St., Suite C

