Communication is very important to us!

Name:_____ DOB:_____

Tel#:_____ other#:_____

Email:_____

How would you like to get appointment reminders?

- ☐ Email
- ☐ Phone call
- ☐ Text

In case of an emergency who shall we contact?

Name:_____ Relationship to patient:_____

Tel#:_____ other#:_____

Shirley Santos, DDS Inc.
17482 Irvine Blvd. Suite B
Tustin, CA 92780
(714)368-0222

Our Commitment: We are committed to providing you affordable quality dental care. We partner with you to achieve the common goal of long term good overall health and a beautiful smile in the most pleasant dental experience.

Appointment Cancellation Policy We will make every effort to remind patients by telephone prior to the appointment but please do not depend on this courtesy. We have found that with the recent popular use of answering machines, pagers, and voice mail, some of our patients are not receiving our reminder calls due to the occasional malfunction of these devices. If you use such devices, we kindly ask that you return our call to confirm that you received our message. If we are unable to contact you directly, your appointment card or appointment phone call will serve as a confirmation of your appointment and it implies your obligation to be present. Your appointment has been reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24 hours notice to avoid a $25.00 cancellation fee. If commitments for appointments are frequently broken, a non- refundable reservation fee equal to the appointment fee may be required. Our ultimate goal is to help you achieve optimum dental health. Broken appointments only serve to delay your dental care and the opportunity to achieve that goal.

Returned Check Policy we accept personal checks for payment. Please make it payable to Shirley Santos, DDS, Inc. Please be aware that we charge a service charge of $25.00 for checks returned to us for insufficient funds. In the event that your check is returned please bring the amount of the check, plus the $25.00 fee for service charge for returned checks to the office in the form of cash, certified check, money order or credit card at: 17482 Irvine Blvd. Suite B Tustin, CA 92780

Signature:_____ Date:_____

PATIENT CARE TXT MESSAGING CONSENT FORM

TEXT MESSAGE ALERTS

I consent to the practice contacting me by txt message for appointment reminders

I acknowledge that appointment reminders by txt are an additional service and that these may not take place on all occasions, and that the responsibility of attending appointments or cancelling them still rests with me. I can cancel the txt message at any time by replying cancel text. Our text messaging system enables patients to respond to txts directly.

Txt messages are generated directly by an office staff. I understand that they may not be answered promptly. Text message charges from my cell phone provider may apply.

I agree to advice the practice if my mobile number changes or if this is no longer in my possession.

Patient Name:_____ Date of birth:_____

Mobile Telephone number: _____

My signature below indicates that I represent and warrant that I am the person legally responsible, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text messaging services.

_____ _____

Signature Date

It is important to note that text communication is not always secure. Text messages can be intercepted and for this reason, we do not communicate personal health information through this method. The practice does not share mobile phone contact details with any external organization.

☐ **I DO NOT CONSENT TO THE PRACTICE CONTACTING ME BY TXT MESSAGING**

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Tustin, CA 92780

PATIENT REGISTRATION FORM

(Please print clearly)

Last Name:_____ MI _____ First Name:_____ Gender: □ Male □ Female

Date of Birth :_____ SS#_____ Email:_____

Patient is: □ Married □ Single □ Divorced □ Separated □Widowed □Minor

If Patient is a minor, give name of parent or guardian:_____

Home Address_____

Street *City* *State* *Zip*

Mailing Address if different_____

Street *City* *State* *Zip*

Home Phone:_____ Work Phone:_____ Other/Cell Phone:_____

How would you like us to contact you: □ Email □ Phone Call □ Txt message □ Other:_____

Primary Language:_____ **Do you need an interpreter?** □Yes □ No

How did you hear about our office:_____

Why are you changing Dentist:_____ **Purpose of Appointment:**_____

Is this office visit for emergency Dental Care? □Yes □No If yes Explain:_____

Preference Of Payment: □ Cash(on day of service) □Credit Card □Check

Employment Information:

Employer Name: _____ Tel Number:_____

Employer Address _____

Street *City* *State* *Zip*

Responsible person: (if different from patient)

Last Name _____ MI _____ First Name _____

Date of Birth _____ Telephone # _____

Address_____

Street *City* *State* *Zip*

Relationship to patient_____

Dental Insurance Information:

Name of Insurance _____ Member ID number_____

Group # _____ Name of Subscriber _____

Employer _____

Relationship to Patient: □ Parent □ Spouse □ Partner □ Other

Authorization and Consent

Payment at the time of services is expected. For your convenience, we accept all major credit cards except American express. Our office will be happy to submit claims to your insurance company. A service charge of 1 ½% per month will be added to all balances 60 days and older. The annual rate of the service charge is 18%. .I understand that Shirley Santos DDS Inc. will make every effort to collect from my insurance company. I hereby Authorize Shirley Santos DDS Inc. to furnish information to insurance carriers concerning my treatment and I hereby assign to the dentist all payments for dental services rendered to me or my dependents. By signing this form, I acknowledge and understand that I am responsible for any amounts not covered by insurance for services rendered to me or my dependents. Our office will accept assignment of benefits from your insurance company with the provisions listed below. It is important to understand, though, the agreement regarding your dental benefits is between you, your employer and your insurance company. The obligation you have with our practice is to pay your treatment regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims. Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to save time and facilitate payment to our office from your insurance company. By having our office process your insurance forms it is important that you understand that this does not eliminate your financial obligation for your treatment. We require you to sign this agreement and /or other necessary assignment documents that may be required by your insurance company. These instruct your insurance company to make payment directly to our office. We require you to pay the estimated co-pay, which is the amount not covered by your insurance company, at the time we provided service to you. The co-pay is only an estimate of charges and may be found to be insufficient after review by your insurance company.

Signed:_____ Date:_____

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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, c

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	
Do you use controlled substances?	Yes No	If yes

Women: Are you...

- Pregnant/Trying to get pregnant?
- Nursing?
- Taking oral contraceptives?

Are you allergic to any of the following?

- Aspirin
- Penicillin
- Codeine
- Acrylic
- Metal
- Latex
- Sulfa Drugs
- Local Anesthetics

Other? If yes

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

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

Have you ever had any serious illness not listed above? Yes No If yes

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:

X Date:_____

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Dental Patient Survey

1.What Dental problems cause you the most trouble?

2.What would you most want to achieve from dental care?

3.How would you describe the perfect Dentist? Be specific

4.What key factors most influence you when choosing a Dentist?

5.What would be the most convenient days for you to visit a dentist?

6.What would be the most convenient hours?

Name: _____ Date:_____