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Thomas H Risbrudt, DDS

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Practicing on Purpose...Mouths need not become money pits!

Chart #:

Patient Name:
Last First MI Preferred Name

Title: **Gender:** Male Female **Family Status:** Married Single Child Other
Mr/Ms/Mrs

Birth Date: **Prev. Visit:** **Email Address:**

Phone: **Best time to call:**
Home Work Ext Mobile

Address:

City State Zip Code

Who is Financially Responsible?

Name & Relationship to Patient (if this information is different from the patient information):

HEALTH & MEDICAL HISTORY

Physician's Name

Date of last physical

Medical Alerts Part One – check any that apply

- | | | |
|--|---|---|
| <input type="checkbox"/> Allergy-Pain Medications
antibiotics | <input type="checkbox"/> Allergy-Barbiturates/Sedatives | <input type="checkbox"/> Allergy-Other |
| <input type="checkbox"/> Allergy-Dental Materials | | |
| <input type="checkbox"/> Allergy-Keflex | <input type="checkbox"/> Allergy-LATEX | <input type="checkbox"/> Allergy-Penicillin |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Taking list of MEDs | <input type="checkbox"/> Allergies | <input type="checkbox"/> Allergy-Amoxicillin |
| <input type="checkbox"/> Allergy-Ampicillin | <input type="checkbox"/> Allergy-Aspirin | <input type="checkbox"/> Allergy-Codeine |
| <input type="checkbox"/> Allergy-Darvon | <input type="checkbox"/> Allergy-Erythromycin | <input type="checkbox"/> Allergy-Iodine |
| <input type="checkbox"/> Allergy-Sulfa | <input type="checkbox"/> Allergy-Tetracycline | <input type="checkbox"/> Allergy-Vicodin |
| <input type="checkbox"/> Anesthetics Reaction | <input type="checkbox"/> Antidepressants | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Chemotherapy TX | <input type="checkbox"/> Cong. Heart Failure | <input type="checkbox"/> Daily Aspirin |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Epilepsy/convulsions | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> GERD/Acid Reflux | <input type="checkbox"/> Graves Disease | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Heart By-Pass | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Heart Stent | <input type="checkbox"/> Hepatitis-A,B,C | <input type="checkbox"/> HIV positive or AIDS |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Mitral Valve Prolaps | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> NO EPI | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Pre-Med / PenVK | <input type="checkbox"/> Pre-Med/Amox |
| <input type="checkbox"/> Pre-Med/Cipro | <input type="checkbox"/> Pre-Med/Clindamycin | <input type="checkbox"/> Pre-Med/Keflex |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Smoker |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Tumors | | |

Other Medical Conditions

- Heart Attack
- Anemia
- Chemical Dependency
- Contact Lens
- Cough, persistent or bloody
- Frequent Urination
- Hemophilia
- Kidney Disease/Disorder
- Low Blood Pressure
- Osteoporosis
- Special Diet
- Stroke
- Ulcer
- Chest Pains
- Back surgery
- Circulatory Problems
- Cortisone Treatments
- Easily Winded
- Frequently Tired
- Jaundice
- Leukemia
- Lung/Respiratory Problems
- Psychiatric Care
- Sexually Transmitted Disease
- Swollen Ankles
- Angina
- Bruise easily
- Colitis
- Cosmetic Surgery
- Excessive Thirst
- Glaucoma
- Joint Replacement
- Liver Disease/Disorder
- Sickle Cell Disease
- Thyroid Condition

Please be specific or explain (use reverse if more space required)

Current medications being taken

Dental History

Check any that apply currently or for which you have been treated

- | | |
|---|--|
| <input type="checkbox"/> Fear | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Sedation Dentistry | <input type="checkbox"/> Premedication before treatments |
| <input type="checkbox"/> Sores or lumps | <input type="checkbox"/> Thermal Sensitivity |
| <input type="checkbox"/> Pressure Sensitivity | <input type="checkbox"/> Bleaching |

Please be specific or explain (use reverse if more space required)

Conditions that may pertain to your bite (check any that apply)

- | | |
|---|---|
| <input type="checkbox"/> Click in Jaw Joints | <input type="checkbox"/> Difficulty chewing/opening/closing |
| <input type="checkbox"/> Locking Jaw | <input type="checkbox"/> Head, Neck, Jaw pain |
| <input type="checkbox"/> Clenching Grinding awareness | <input type="checkbox"/> Grinding previously noted |
| <input type="checkbox"/> Orthodontic Treatment | <input type="checkbox"/> Teeth removed for orthodontics |
| <input type="checkbox"/> Biting cheeks | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Periodontal/Gum Disease | <input type="checkbox"/> Failing Dentistry |
| <input type="checkbox"/> Multiple root canal fillings | <input type="checkbox"/> TMJ diagnosis |
| <input type="checkbox"/> TMJ Treatment | <input type="checkbox"/> Nightguards/Splints |

If you are having some discomfort, how often does it require medication?

- Routinely Intermittently Rarely

Requires the services of other professionals to manage the discomfort (chiropractor, neurologist, physical therapist, etc.)

Frequency of Discomfort

- Daily In the morning In the evening Intermittent Constant

Consent for Services & Acknowledgements (legal requirements and so on...)

I certify that I have read, understand and have answered the medical and dental history questions to the best of my knowledge. I understand that providing incomplete or incorrect information can be dangerous to my health. I will not hold Thomas H. Risbrudt, D.D.S., or any other member of his team responsible for any errors or omissions that I have made in the completion of the form and I have had any related questions answered. I further understand that it is my responsibility to advise of any changes in my medical or dental history at every appointment and record changes in writing.

By checking this box, I as the patient named or responsible party acknowledge that I was presented with and understood the NOTICE OF PRIVACY PRACTICES.

I the undersigned is hereby known as the responsible party and information for myself or for whom I am responsible is detailed above in this form and is true and correct. With my signature, I hereby authorize Thomas H. Risbrudt, D.D.S., with the help of California licensed care providers including California Licensed Hygienists and/or Assistants to take x-rays, diagnostic casts, photographs, or any other diagnostic aids deemed appropriate by the doctor and agreed to by me to make a thorough diagnosis of the named patients conditions. I also authorize Thomas H. Risbrudt, D.D.S. to perform any and all forms of dental treatment, administer or prescribe medication and therapy that may be Indicated, and further authorize and consent that Thomas H. Risbrudt choose and employ such assistances as deemed appropriate. I also understand that the use of anesthetic agents embodies a certain risk.

I also understand that the responsibility for payment for dental services rendered in this office for myself, or the patient named are my responsibility at the time services are rendered unless other arrangements have been made in writing.

With my signature I understand Thomas H. Risbrudt, D.D.S. is out-of-network with all insurance companies, therefore the liability for fees for services rendered and disputes or grievances with my insurance carrier due to policy limitations is solely handled by me; the responsible party. I understand that any unpaid amounts are subject to a 1.5% finance charge (18% annually) and can be added to my balance over 30 days. In the event of default, I the undersigned promise to pay all interest on the indebtedness, together with such collections costs and reasonable attorney fees as may be required to effect collection on this note.

Response Date: _____

As you reach the treatment area, you will be asked to review your medical history on the computer and advise us of any changes. In the interest of respecting the law, your rights and your health, thank you for reviewing the attached:

**Health Information and Private Practices Act (HIPPA)
The Dental Materials Fact Sheet
Mutual Respect agreement**

Please keep any you would like for your records. A printout is available too. There are four statements which you will acknowledge with your electronic signature when you reach the treatment area;

About dental insurance and fees

You can count on us to provide standard claim forms and supportive information the day of service. When your decision to Invest in your health is dependent upon what contributions your dental insurance company will make, we invite you to talk with us plainly and up front. We don't know what your insurance will cover with any degree of assurity. We can give you our best guess from years of experience. If, understandably, you need certainty about your benefits, it's best that you correspond directly with them. Wets familiar with the rules they apply to limit their liability. Well do all we can to supply convincing documentation and appreciate you remembering the relationship is with you, your employer and your insurance company.

We're not growing our business based on insurance benefits. Generally speaking most dental insurance supports remedial care.

What we do best is deliver state of the art care and exceptional service; applying years of experience that enable us to keep abreast of arid adjudicate the rapid changes in health sciences, treatments and technology. We think that's where our obligation lies rather than being insurance administrators.

We also realize the finance business is best left to other professionals. So we're getting out of that business too but can direct you to some sources. The bottom line is we are pleased to be of service and like every other business, only expect to be paid as the care, services and treatment is delivered.

We're always willing to be understanding so all you have to do is talk to any one of us. We don't operate by rules and policies. We operate from understanding each other.

Consent for Services & Acknowledgements (legal requirements and so on...)

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I as the patient named or responsible party acknowledge that I was presented with and understood the NOTICE OF PRIVACY PRACTICES.

I as the patient named or responsible party acknowledge that I was presented with and understood the DENTAL MATERIALS FACT SHEET.

The undersigned is hereby known as the responsible party and information for myself or for whom I am responsible is detailed above in this form and is true and correct. With my signature, I hereby authorize Thomas H. Risbrudt, D.D.S. with help of California licensed care providers including California Licensed Hygienists and/or Assistants to take x-rays, diagnostic casts, photographs, or any other diagnostic aids deemed appropriate by the doctor and agreed to by me to make a thorough diagnosis of the named patient's conditions. I also authorize Thomas H. Risbrudt, D.D.S. to perform any and all forms of dental treatment, administer or prescribe medication and therapy that may be indicated, and further authorize and consent that Thomas H. Risbrudt choose and employ such assistances as deemed appropriate. I also understand that the use of anesthetic agents embodies a certain risk.

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With my signature I understand Thomas H. Risbrudt, D.D.S. is out-of-network with all insurance companies, therefore the liability for fees for services rendered and disputes or grievances with my insurance carrier due to policy limitations is solely handled by me; the responsible party. I understand that any unpaid amounts are subject to a 1.5% finance charge (18% annually) and can be added to my balance over 30 days. In the event of default I the undersigned promise to pay all interest on the indebtedness, together with such collections costs and reasonable attorney fees as may be required to effect collection on this note.

Your care provider will acquire an electronic signature for our records when you reach the treatment area. Thank you.

Response Date: _____