Sharon L. Albright, D.D.S., Inc.
AESTHETIC RESTORATIVE DENTISTRY

Salutation (Please circle one): Dr. Mr. Mrs. Miss Ms. ♦ How should we address you? ☐First name ☐Last name ☐Other:_____

Patients' name:_____ S.S.N._____

Address:_____City:_____ State:_____ Zip Code:_____

Home Phone #: (____)_____ Age:_____ Date of Birth: _____ Sex: Male Female

Marital Status: (Please circle one) Single Divorced Separated Widowed Married: Spouse:_____

Employer:_____Occupation:_____Work Phone #: _____

In case of emergency, call:_____(_____)_____
Name Phone # Relationship

Who may we thank for referring you to us?_____

Cell Phone Number:_____ E-mail Address:_____
(For confidential voice messages) (For appointment confirmation)

Are you available for appointments with 24 hours notice? ☐ Yes ☐ No or 48 hours notice? ☐ Yes ☐ No

PLEASE COMPLETE THIS SECTION ONLY IF YOU ARE THE PATIENT'S PARENT OR GUARDIAN

Name:_____ S.S.N.:_____

Address:_____City:_____ State:_____ Zip Code:_____

Home Phone #: (____)_____ Age:_____ Date of Birth:_____ Sex: Male Female

Marital Status: (Please circle one) Single Divorced Separated Widowed Married: Spouse:_____

Employer:_____ Work Phone #: _____

PLEASE READ THE FOLLOWING REGARDING BROKEN APPOINTMENT FEES

There will be a $60 minimum charge for broken appointments and appointment cancellations without a two business day notice. If you know that you cannot keep an appointment, please call and notify us as soon as possible. With a two business day notice you will avoid the broken appointment fee and we may provide care for another patient during the time we set aside to care for you.

PLEASE READ, THEN SIGN THE FOLLOWING
CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

I consent, and certify that I am legally able to give consent, for the above named patient to receive dental and/or medical evaluation and treatment from Sharon L. Albright, D.D.S., Inc. for conditions that necessitate telephone calls and/or visits to the dentist and any other conditions that are discussed during telephone calls and/or visits to the dentist. I hereby assign all dental benefits to which I am entitled for treatment rendered by Sharon L. Albright, D.D.S., Inc., I agree to pay all fees for services to the patient, including those not paid by insurance. I authorize release of any information related to this patient's health insurance claims as well as payment directly to Sharon L. Albright, D.D.S., Inc. of the insurance benefits otherwise payable to me.

Signature:_____Relationship: Self Parent Guardian Date:_____

PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST WITH THIS COMPLETED FORM.
THANK YOU.

Eaglesoft Medical History - Customized for Sharon Albright DDS Inc

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around the mouth, it is important to remember that the mouth is a part of the entire body. Medical conditions th you may have or had, and medications that you take or have taken are very important in determining the dental care and treatment you should receive. Thank you for

Reason for your visit today:

☐ Exam ☐ Cleaning ☐ Pain ☐ Fillings
☐ Crown/Bridge ☐ Denture/Partial ☐ Other

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had surgery in the hospital?	○ Yes ○ No	If yes
Have you ever had a serious illness?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, herbs/supplements, or drugs?	○ Yes ○ No	If yes
Do you take, or have you ever taken, diet drugs such as Phen-fen, Redux or Pondimen?	○ Yes ○ No	If yes
Do you take, or have you ever taken, Fosamax, Boniva or Actonel, or any other medication	○ Yes ○ No	
Do you use controlled substances?	○ Yes ○ No	If yes
Do you use tobacco?	○ Yes ○ No	If yes
Do you drink alcoholic beverages?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	If yes

Are you allergic to any of the following?

☐ Acrylic ☐ Aspirin ☐ Certain anesthetics ☐ Certain metals
☐ Codeine ☐ Ibuprofen ☐ Latex ☐ Penicillin
☐ Sulfa Drugs ☐ Tetracycline ☐ Tylenol ☐ Other

Women: Are you...

☐ Pregnant/Possibly Pregnant? ☐ Breastfeeding? ☐ Taking birth control pills?

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

Adrenal Disease	○ Yes ○ No	Drug/Alcohol Abuse	○ Yes ○ No	Herpes	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No
AIDS/HIV+/ARC	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Persistent Cough	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Endocarditis	○ Yes ○ No	High Blood Sugar	○ Yes ○ No	Physical Difficulties	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Enlarged Heart	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Pneumonia	○ Yes ○ No
Anemia	○ Yes ○ No	Epilepsy/Seizures	○ Yes ○ No	Hives/Rash	○ Yes ○ No	Psychiatric Care	○ Yes ○ No
Arthritis	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Immunosuppression	○ Yes ○ No	Pulmonary Shunt	○ Yes ○ No
Artificial Heart Valve(s)	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Intestinal Disease	○ Yes ○ No	Radiation Therapy	○ Yes ○ No
Artificial Joint(s)	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heart Beat	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Asthma	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Jaundice	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Blood Disease	○ Yes ○ No	Glaucoma	○ Yes ○ No	Joint Pain/Swelling	○ Yes ○ No	Rheumatoid Arthritis	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Gout	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Shingles	○ Yes ○ No
Breathing Problem	○ Yes ○ No	Hay Fever	○ Yes ○ No	Leukemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Heart Abnormality	○ Yes ○ No	Liver Disease	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Cancer	○ Yes ○ No	Heart Attack/Heart Failure	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Stomach Problems	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Low Blood Sugar	○ Yes ○ No	Stroke	○ Yes ○ No
Chest Pain / Angina	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Problem(s)	○ Yes ○ No	Lupus	○ Yes ○ No	TMJ Problems	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Surgery	○ Yes ○ No	Mental Difficulties	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Convulsions	○ Yes ○ No	Hemophilia	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tumors/Growths	○ Yes ○ No
Cortisone/Steroids	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Neck/Back Pain	○ Yes ○ No	Ulcers	○ Yes ○ No
Diabetes	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Veneral Disease	○ Yes ○ No

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

Do you have family members with any of the following? (Check all that apply)

☐ Heart Disease ☐ Tuberculosis ☐ Bleeding Problems ☐ Diabetes
☐ Cancer

Have you ever been referred to or been treated by a dental specialist? (Check all that apply)

☐ Oral Surgeon ☐ Oral Pathologist ☐ Endodontist ☐ Periodontist
☐ Orthodontist ☐ Prosthodontist ☐ Pedodontist

Comments:

To the best of my knowledge, the questions on this form have been answered accurately. I understand that withholding or providing incorrect information can be dangerous to my (or the patient's) health. I also agree to inform the doctor and/or staff of any changes in my (or the patient's) medical status.

Signature of Patient, Parent or Legal Guardian:

X Date:_____

Sharon L. Albright, D.D.S., Inc.
AESTHETIC RESTORATIVE DENTISTRY

6333 Telegraph Avenue ♦ Suite 205 ♦ Oakland, CA 94609

Telephone: (510) 658-1996 Fax: (510) 658-6756

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I,_____, have received a copy of this office's Notice of Privacy Practices.
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

D Individual refused to sign

D Communications barriers prohibited obtaining the acknowledgement

D An emergency situation prevented us from obtaining acknowledgement

D Other (Please Specify)

_____

_____

CONSENT FOR DENTAL TREATMENT
AND
ACKNOWLEDGEMENT OF DENTAL MATERIAL FACT SHEET RECEIPT

Patient Name:_____ Date of Birth:_____

Patient, Parent or Legal Guardian: Please initial each statement below as you agree. If you have any questions please notify the doctor before you complete this form.

1. _____ I consent, and certify that I am legally able to give consent, for the above named patient to receive dental examination and treatment from Sharon L. Albright, D.D.S., Inc.

2. _____ I consent to diagnostic X-Rays and digital imaging as required by the doctor for examination, diagnosis, treatment, patient education and record keeping.

3. _____ I authorize the doctor and staff to perform all treatment she/he and I agree upon and to employ such assistance and tools as required to provide appropriate care.

4. _____ I agree to the use of anesthetics and other medications as necessary, understanding that the use of anesthetics and other medications embody certain risks. In rare instances nerve injury (temporary or permanent) may result from an injection and patient reaction to anesthetics and other medications may require medical attention (routine or emergency).

5. _____ I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and/or sore. This may make it difficult to open wide for several days. I agree to notify the doctor if this or other symptoms arise as they may be an indication of another problem.

6. _____ I understand that I may request and receive an explanation of the nature, risks, benefits, consequences of treatment and of no treatment as well as alternatives to any proposed treatment prescribed by the doctor at any time.

7. _____ I acknowledge that I have received a copy of the **Dental Board of California's** dental materials fact sheet, entitled **"The Facts About Fillings"** dated May 2004.

8. _____ Women: If you are pregnant or think you may be pregnant please let us know. Dental treatment may be performed during any stage of pregnancy but the safest time to perform dental treatment is during the second trimester (weeks 13 - 27). Waiting until the second trimester decreases the risk of interfering in the normal development of your baby's vital organs during the first trimester (weeks 1 – 12) and possible triggering of premature labor during the third trimester (weeks 28 – birth, approx. 40 weeks). Periodontal Therapy (teeth cleaning) to reduce the amount of harmful bacteria in your body and Urgent Care (treatment to prevent true dental emergencies) will be performed during the second trimester and in some cases until week 32 of pregnancy. Dental emergencies (e.g. uncontrolled pain or bleeding, oral/facial swelling and fractured teeth) will be addressed during any stage of pregnancy and we will take appropriate precautions to ensure the health and safety of you and your baby.

Patient Signature:_____ Date:_____

Responsible Party's Signature:_____ Date:_____

Responsible Party's Relationship to Patient: (Please check one below)
- ☐ Parent with Legal Custody
- ☐ Guardian with Legal Custody
- ☐ Qualified Relative of a Minor – Qualified Relatives must complete a Caregiver's Authorization Affidavit

Witness' Signature:_____ Date:_____

Dental Health History

Patient Name:_____

Occupation:_____ Employer:_____

1. How have most of your dental visits been in the past, Good Bad Indifferent

2. What is the worst part of a dental visit for you?

3. How can we make visits easier or more pleasant for you?

4. Would you say that the condition of your teeth, gums and jaw joints are:
   A. Comfortable
   B. Somewhat comfortable
   C. Uncomfortable

5. Do you feel that the appearance of your smile is:
   A. Excellent
   B. Good
   C. Fair
   D. Poor

6. Are you happy with the color of your teeth?

7. Have you noticed any changes in your smile or with your teeth over time?

8. On a scale of 1 to 10 with 1 being Poor and 10 being Excellent how would you rate your present dental health?

9. On the same scale of 1 to 10 where would you like your dental health to be in 5 years?

10. How would you describe your intentions at this point regarding your dental health:
    A. I will do whatever is necessary to keep my natural teeth healthy and presentable
    B. I want to keep my teeth but a have a certain budget of time and money that I am willing to spend on them.
    C. My teeth are not a high priority, I just don't want them to hurt.

11. How would you feel about wearing full or partial dentures?