Michael Thylin, DDS

3144 El Camino Real, Suite 203, Carlsbad, CA 92008 ◇ Phone: 760-730-9700

PATIENT INFORMATION

Date: _____ ID# or SS# _____

Patient: _____

Address: _____

_____
City State Zip

Sex: ☐ M ☐ F Age: _____ Birthdate: _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation: _____

Employer: _____

Employer Address: _____

Employer Phone: _____

Spouse's Name: _____

Birthdate: _____ SS# _____

Occupation: _____

Spouse's Employer: _____

Whom m ay we thank for referring you? _____

_____

DENTAL INSURANCE

Subscriber: _____ DOB: _____

Relationship to Patient: _____

Employer: _____

Insurance Co: _____ Phone: _____

ID #: _____ Group #: _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber: _____ DOB: _____

Relationship to Patient: _____

Employer: _____

Insurance Co: _____ Phone: _____

ID #: _____ Group #: _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with:

_____ and assign directly to Michael Thylin, DDS, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions

_____
Responsible Party Signature

_____
Relationship Date

Contact Information

Home ( ) Work ( ) Cell ( )

Email _____

Best time and place to reach you

Additional Contact (optional): Relationship:

Home Phone: ( ) Work Phone: ( )

DENTAL HISTORY

☐ Y=Yes ☐ N=No

Reason for today's visit? _____

_____

Former Dentist: _____

City / State: _____

Date of last dental visit: _____

Date of last dental x-rays: _____

Check (✓) all of the following that apply...

Bad Breath	☐ Y	☐ N
Bleeding Gums	☐ Y	☐ N
Blisters on lips or mouth	☐ Y	☐ N
Jaw pain or tiredness	☐ Y	☐ N

How often do you floss? _____

Burning sensation on tongue	☐ Y	☐ N
Chew on one side of mouth	☐ Y	☐ N
Cigarette, pipe, of cigar Smoking	☐ Y	☐ N
Clicking or popping jaw	☐ Y	☐ N
Dry mouth	☐ Y	☐ N
Fingernail biting	☐ Y	☐ N
Food collection between teeth	☐ Y	☐ N
Foreign objects	☐ Y	☐ N
Grinding teeth	☐ Y	☐ N
Gums swollen or tender	☐ Y	☐ N
Lip or cheek biting	☐ Y	☐ N

How often do you brush? _____

Loose teeth or broken fillings	☐ Y	☐ N
Mouth breathing	☐ Y	☐ N
Mouth pain, brushing	☐ Y	☐ N
Orthodontic treatment	☐ Y	☐ N
Pain around ear	☐ Y	☐ N
Periodontal treatment	☐ Y	☐ N
Teeth sensitive to cold	☐ Y	☐ N
Teeth Sensitive to heat	☐ Y	☐ N
Sensitive to sweets	☐ Y	☐ N
Sensitivity when biting	☐ Y	☐ N
Sores or growths in mouth	☐ Y	☐ N

~ OVER ~

HEALTH HISTORY

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes____ No____

Check (✓) if you have ever had or now have the following: ❑ Y=Yes ❑ N=No

AIDS / HIV	❑Y	❑N	Emphysema	❑Y	❑N	Radiation Treatment	❑Y	❑N
Anemia	❑Y	❑N	Epilepsy	❑Y	❑N	Respiratory Disease	❑Y	❑N
Arthritis, Rheumatism	❑Y	❑N	Fainting of dizziness	❑Y	❑N	Rheumatic Fever	❑Y	❑N
Artificial Heart Valves	❑Y	❑N	Glaucoma	❑Y	❑N	Scarlet Fever	❑Y	❑N
Artificial Joints	❑Y	❑N	Headaches/Migraines	❑Y	❑N	Shortness of Breath	❑Y	❑N
Asthma	❑Y	❑N	Heart Problems or Murmur	❑Y	❑N	Sinus Trouble	❑Y	❑N
Back Problems	❑Y	❑N	Hepatitis Type: _____	❑Y	❑N	Skin Rash	❑Y	❑N
Bleeds abnormally easy	❑Y	❑N	Herpes	❑Y	❑N	Special Diet	❑Y	❑N
Blood Disease	❑Y	❑N	High Blood Pressure	❑Y	❑N	Stroke	❑Y	❑N
Cancer	❑Y	❑N	Jaundice	❑Y	❑N	Swelling of Feet or Ankles	❑Y	❑N
Chemical Dependency	❑Y	❑N	Jaw Pain	❑Y	❑N	Swollen Neck Glands	❑Y	❑N
Chemotherapy	❑Y	❑N	Kidney Disease	❑Y	❑N	Thyroid Problems	❑Y	❑N
Circulatory Problems	❑Y	❑N	Liver Disease	❑Y	❑N	Tonsillitis	❑Y	❑N
Congenital Heart Lesions	❑Y	❑N	Low Blood Pressure	❑Y	❑N	Tuberculosis	❑Y	❑N
Cortisone Treatments	❑Y	❑N	Mitral Valve Prolapse	❑Y	❑N	Tumor / growth on head/neck	❑Y	❑N
Cough, Persistent or bloody	❑Y	❑N	Nervous Problems	❑Y	❑N	Ulcer	❑Y	❑N
Diabetes	❑Y	❑N	Pacemaker	❑Y	❑N	Venereal Disease	❑Y	❑N
Do you wear contact lenses?	❑Y	❑N	Psychiatric Care	❑Y	❑N	Weight loss, unexplained	❑Y	❑N
Acid Reflux/Gerd	❑Y	❑N	Immunications up to date	❑Y	❑N	HPV	❑Y	❑N
Sleep Apnea	❑Y	❑N	Bone Density problems	❑Y	❑N	Skin Cancer	❑Y	❑N
Smoker/Smokeless Tobacco	❑Y	❑N						

I usually take antibiotics prior to dental treatment. ❑Y ❑N

Have you had Bisphosphonate Therapy: Aledronate (Fosamax), Risedronate (Actonel), Ibandronate (Boniva), Zoledronate (Zometa), Etidronate (Didronel) Pamidronate (Aredia) Yes_____ No_____

I have had major surgery. ❑Y ❑N Year: _____ Type of operation: _____

Women:

Are you pregnant? ❑Y ❑N Due date_____ Are you nursing? ❑Y ❑N Taking birth control pills? ❑Y ❑N

MEDICATIONS: List any medications you are currently taking

Medicine:_____ Condition:_____
Medicine:_____ Condition:_____
Medicine:_____ Condition:_____
Medicine:_____ Condition:_____
Medicine:_____ Condition:_____
Medicine:_____ Condition:_____
Vitamins, Suppl., herbals _____

ALLERGIES

❑ Aspirin
❑ Barbiturates (sleeping pills)
❑ Codeine
❑ Iodine
❑ Latex, Metal, Plastics
❑ Local Anesthetic
❑ Penicillin
❑ Sulfa
❑ Other_____

Physicians Name:_____ Phone: _____
Pharmacy Name:_____ Phone: _____

In the event of an emergency, please contact:

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

Initial medical/dental health reviewed by:

Name: _____ Date: _____
Name: _____ Date: _____
Name: _____ Date: _____

X_____
Patient signature

X_____
If patient is under age, parent or guardian signature

HIPAA CONSENT FORM

The Health Insurance Portability and Accountability Act of 1996 provide safeguards to protect your privacy. These safeguards include restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you or your family with treatment. HIPAA provides certain rights and protections to you as the patient. We must balance these needs with our goal of providing you with quality service and care. For this reason, our practice has adopted the following policies:

(1) Patient information will be kept confidential except as is necessary to provide treatment or to ensure that all administrative matters related to your care are handled appropriately. Patient files may be stored in open file racks but will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left in administrative areas such as the front office, Doctor's office, etc. The patient agrees to the normal procedures utilized within the facility for the handling of charts, patient records, PHI and other documents or information.

(2) It is the policy of the office to remind patients of their appointments. This may be done by telephoning patients or by any other means convenient for the practice.

(3) The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but agree to abide by the confidentiality rules of HIPAA.

(4) The patient understands and agrees to inspections of the office and the review of documents which may include PHI by government agencies or insurance companies in the normal performance of their duties.

(5) The patient agrees to bring any concerns or complaints regarding privacy to the attention of the Doctor or office manager.

(6) Your confidential information will not be used for the purposes of advertising or marketing of products, goods, or services. Such prohibition does not include treatment/product samples or goods of nominal value.

(7) The practice agrees to provide the patient with access to their records in accordance with state law.

(8) The practice may change, add, delete, or modify any of these provisions to better serve the needs or both the practice and the patient.

I, _____, do hereby agree to the terms set forth above and any subsequent changes in office policy. I understand that this consent shall remain in force so long as I am a patient of this practice.

_____ _____

Patient Signature (parent/guardian if minor) Date

Carlsbad Coastal Dental
3144 El Camino Real
Suite 203
Carlsbad, CA 92008
760.730.9700
HIPPA Contact:
Lauren
Office Manager

Carlsbad Coastal Office Policies

To Our Patients:

The following information about our office policies is provided for your understanding. We feel that the more you know about our policies and methods of practice, the more we can be of service to you and avoids and possible misunderstandings and frustration.

Financial Policy

- We will kindly ask that you pay your estimated portion at the time of service, which may include a yearly deductible if you have dental benefits.
- As a courtesy, we will gladly bill your insurance provider when you provide us with the current information. We expect all dental claims be paid within 30 days of submission. You understand that you are financially responsible for all charges whether or not paid by your dental insurance company.
- We accept credit cards (Visa, MasterCard, American Express, and Discover).
- For patients who qualify, we offer third party financing through a company that offers a revolving line of credit that can be used by the whole family.
- After x-rays and examination, you are entitled to and will receive an estimate for services recommended as well as fees associated with them. All estimates are based upon conditions viewed at the time of diagnosis. Unforeseen circumstances can occasionally occur and may alter the estimated fee.

Office Scheduling Policy

- When making an appointment, please realize we design our schedule to offer individual quality care for you. We need 48 hours (two working days) notice to change an appointment. This advance notice allows us to offer this valuable chair time to another patient who is in need of treatment. We realize that circumstances sometimes prevent our patients from keeping their appointment. Regretfully, you will be billed a minimum of **$50.00** for the lost time if a 48 hour notice isn't received.

Notice of Privacy Practices (HIPPA)

- A copy of our office Notice of Privacy Practices (HIPPA) is attached to the New Patient paperwork which you are being asked to complete. Upon your request, we will be happy to provide you with a copy of our Privacy Practices.

Dental Materials Fact Sheet

- A laminated copy of **Facts About Fillings** (Dental Board of California Publication) is available for your review. I have acknowledged I have received/reviewed the Dental Material Fact Sheet dated May 2004 from Dr. Thylin as required by state law.

_____ _____

Patient Signature (parent/guardian if minor) **Date**