Light Breeze Dental

2500 ALTON PKWY STE 203 | IRVINE CA, 92606 |

PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ (FIRST / MI / LAST) DATE _____

ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

E-MAIL _____ CELL PHONE _____ HOME PHONE _____

SS#/SIN _____ BIRTHDATE _____ OCCUPATION _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

SPOUSE OR PARENT'S/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ SS#/SIN _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

ITEM 07-0515767-2700

X _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

REGISTRATION

PATIENT MEDICAL HISTORY

PATIENTS NAME_____DATE OF BIRTH_____

	YES	NO
1. ARE YOU IN GOOD HEALTH	[ ]	[ ]
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR	[ ]	[ ]
3. DATE OF YOUR LAST PHYSICAL EXAM_____		
4. PHYSICIAN'S NAME_____		
ADDRESS_____		
PHONE NUMBER_____		
5. ARE YOU UNDER A PHYSICIAN'S CARE NOW	[ ]	[ ]
6. HAVE YOU EVER BEEN HOSPITALIZED OR HAD A MAJOR OPERATION	[ ]	[ ]
PLEASE EXPLAIN_____		
7. HAVE YOU EVER HAD A SERIOUS HEAD OR NECK INJURY	[ ]	[ ]
8. ARE YOU TAKING ANY MEDICATIONS, PILLS, DRUGS INCLUDING NON PRESCRIPTION	[ ]	[ ]
IF YES, WHAT MEDICINE(S) ARE YOU TAKING_____		
_____		
9. DO YOU USE CONTROLLED SUBSTANCES	[ ]	[ ]
10. HAVE YOU HAD ANY ABNORMAL BLEEDING	[ ]	[ ]
11. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION	[ ]	[ ]
12. ARE YOU ON A SPECIAL DIET	[ ]	[ ]
13. DO YOU TAKE, OR HAVE YOU EVER TAKEN FEN-PHEN/REDUX	[ ]	[ ]
14. HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL OR ANY OTHER MEDICATION CONTAINING BISPHOSPHONATES	[ ]	[ ]

	YES	NO
15. DO YOU USE TOBACCO	[ ]	[ ]
16. ARE YOU WEARING CONTACT LENSES	[ ]	[ ]
17. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)	[ ]	[ ]
18. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT	[ ]	[ ]

WOMEN ONLY:	YES	NO
ARE YOU PREGNANT, THINK YOU MAY BE, OR TRYING TO GET PREGNANT	[ ]	[ ]
ARE YOU NURSING	[ ]	[ ]
ARE YOU TAKING BIRTH CONTROL PILLS	[ ]	[ ]

ARE YOU ALLERGIC /HAD REACTIONS TO

ASPIRIN	Y[ ]	N[ ]	PENICILLIN	Y[ ]	N [ ]
CODEINE	Y[ ]	N[ ]	LOCAL ANESTHETICS	Y[ ]	N[ ]
ACRYLIC	Y[ ]	N[ ]	METAL	Y[ ]	N[ ]
SULFA	Y[ ]	N[ ]	LATEX/RUBBER	Y[ ]	N [ ]
IODINE	Y[ ]	N[ ]	BARBITURATES,		
OTHER_____			SEDATIVES OR		
OTHER_____			SLEEPING PILLS	Y[ ]	N [ ]

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING

Y[ ]	N[ ]	AIDS/HIV POSITIVE	Y[ ]	N[ ]	EXCESSIVE THIRST	Y[ ]	N[ ]	MITRAL VALVE PROLAPSE
Y[ ]	N[ ]	ALZHEIMER'S DISEASE	Y[ ]	N[ ]	FAINTING SPELLS/DIZZINESS	Y[ ]	N[ ]	OSTEOPOROSIS
Y[ ]	N[ ]	ANAPHYLAXIS	Y[ ]	N[ ]	FREQUENT COUGH	Y[ ]	N[ ]	PAIN IN JAW JOINTS
Y[ ]	N[ ]	ANEMIA	Y[ ]	N[ ]	FREQUENT DIARRHEA	Y[ ]	N[ ]	PARATHYROID DISEASE
Y[ ]	N[ ]	ANGINA	Y[ ]	N[ ]	FREQUENT HEADACHES	Y[ ]	N[ ]	PSYCHIATRIC CARE
Y[ ]	N[ ]	ARTHRITIS/GOUT	Y[ ]	N[ ]	GENITAL HERPES	Y[ ]	N[ ]	RADIATION TREATMENTS
Y[ ]	N[ ]	ARTIFICIAL HEART VALVE	Y[ ]	N[ ]	GLAUCOMA	Y[ ]	N[ ]	RECENT WEIGHT LOSS
Y[ ]	N[ ]	ARTIFICIAL JOINT	Y[ ]	N[ ]	HAY FEVER	Y[ ]	N[ ]	RENAL DIALYSIS
Y[ ]	N[ ]	ASTHMA	Y[ ]	N[ ]	HEART ATTACK/FAILURE	Y[ ]	N[ ]	RHEUMATIC FEVER
Y[ ]	N[ ]	BLOOD DISEASE	Y[ ]	N[ ]	HEART MURMUR	Y[ ]	N[ ]	RHEUMATISM
Y[ ]	N[ ]	BLOOD TRANSFUSION	Y[ ]	N[ ]	HEART PACEMAKER	Y[ ]	N[ ]	SCARLET FEVER
Y[ ]	N[ ]	BREATHING PROBLEM	Y[ ]	N[ ]	HEART TROUBLE/DISEASE	Y[ ]	N[ ]	SHINGLES
Y[ ]	N[ ]	BRUISE EASILY	Y[ ]	N[ ]	HEMOPHILIA	Y[ ]	N[ ]	SICKLE CELL DISEASE
Y[ ]	N[ ]	CANCER	Y[ ]	N[ ]	HEPATITIS A	Y[ ]	N[ ]	SINUS TROUBLE
Y[ ]	N[ ]	CHEMOTHERAPY	Y[ ]	N[ ]	HEPATITIS B OR C	Y[ ]	N[ ]	SPINA BIFIDA
Y[ ]	N[ ]	CHEST PAINS	Y[ ]	N[ ]	HERPES	Y[ ]	N[ ]	STOMACH/INTESTINAL DISEASE
Y[ ]	N[ ]	COLD SORES/FEVER BLISTERS	Y[ ]	N[ ]	HIGH BLOOD PRESSURE	Y[ ]	N[ ]	STROKE
Y[ ]	N[ ]	CONGENITAL HEART DISORDER	Y[ ]	N[ ]	HIGH CHOLESTEROL	Y[ ]	N[ ]	SWELLING OF LIMBS
Y[ ]	N[ ]	CONVULSIONS	Y[ ]	N[ ]	HIVES OR RASH	Y[ ]	N[ ]	THYROID DISEASE
Y[ ]	N[ ]	CORTISONE MEDICINE	Y[ ]	N[ ]	HYPOGLYCEMIA	Y[ ]	N[ ]	TONSILLITIS
Y[ ]	N[ ]	DIABETES	Y[ ]	N[ ]	IRREGULAR HEARTBEAT	Y[ ]	N[ ]	TUBERCULOSIS
Y[ ]	N[ ]	DRUG ADDICTION	Y[ ]	N[ ]	KIDNEY PROBLEMS	Y[ ]	N[ ]	TUMORS OR GROWTHS
Y[ ]	N[ ]	EASILY WINDED	Y[ ]	N[ ]	LEUKEMIA	Y[ ]	N[ ]	ULCERS
Y[ ]	N[ ]	EMPHYSEMA	Y[ ]	N[ ]	LIVER DISEASE	Y[ ]	N[ ]	VENEREAL DISEASE
Y[ ]	N[ ]	EPILEPSY OR SEIZURES	Y[ ]	N[ ]	LOW BLOOD PRESSURE	Y[ ]	N[ ]	YELLOW JAUNDICE
Y[ ]	N[ ]	EXCESSIVE BLEEDING	Y[ ]	N[ ]	LUNG DISEASE			

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 patients) health. It is my responsibility to inform the dental office of any changes in medical status

Signature of patient, parents, guardian Date Signature of treating dentist Date

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PATIENT DENTAL HISTORY

WE WILL STRIVE TO PROVIDE YOU WITH THE BEST POSSIBLE DENTAL CARE.

HOW DID YOU HEAR ABOUT US _____

WHOM MAY WE THANK FOR REFERRING YOU _____

REASON FOR THIS VISIT _____

WHEN WAS YOUR LAST DENTAL VISIT _____ WHAT WAS DONE THEN _____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN...WHEN...WHERE _____

IS YOUR DRINKING WATER FLUORIDATED _____

	YES	NO
DO YOU HAVE TROUBLE FALLING ASLEEP AT NIGHT OR FEEL EXCESSIVELY SLEEPY DURING THE DAY ?	☐	☐
HAVE YOU EVER BEEN DIAGNOSED WITH A SLEEP DISORDER?	☐	☐
DO YOU USE OR HAVE USED CPAP THERAPY?	☐	☐

	YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING	☐	☐
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS	☐	☐
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS	☐	☐
DO YOU FEEL PAIN TO ANY OF YOUR TEETH	☐	☐
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH	☐	☐
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES	☐	☐
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
CLICKING	☐	☐
PAIN (JOINT, EAR, SIDE OF FACE)	☐	☐
DIFFICULTY IN OPENING OR CLOSING	☐	☐
DIFFICULTY IN CHEWING	☐	☐
DO YOU HAVE FREQUENT HEADACHES	☐	☐
DO YOU CLENCH OR GRIND YOUR TEETH	☐	☐

	YES	NO
DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY	☐	☐
HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH	☐	☐
DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH	☐	☐
HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS)	☐	☐
EVER WORN A BITE PLATE OR OTHER APPLIANCE	☐	☐
HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST	☐	☐
HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS	☐	☐
DO YOU WEAR DENTURES OR PARTIALS	☐	☐
IF YES, DATE OF PLACEMENT _____		
HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS	☐	☐

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? _____

ARE YOU HAPPY WITH APPEARANCE AND COLOR OF YOUR TEETH? IF NOT, EXPLAIN: _____

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

_____ _____

Signature of Patient or Parent/Guardian if Minor *Date*

_____ _____

Signature of Patient or Parent/Guardian if Minor *Date*

_____ _____

Doctor's Signature *Date*

HEALTH HISTORY

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XRAY CONSENT AND POLICY

This office follows the guidelines of the American Dental Association and recommends that FULL MOUTH XRAYS (FMX) BE TAKEN ONCE EVERY 3 TO 5 YEARS and BITEWING XRAYS at least once a year for caries diagnosis.

Dental x-rays allow the dentist to diagnose and treat conditions that cannot be detected during a clinical examination. Dental x-rays are a part of a comprehensive oral examination. Dental x-ray films detect much more than cavities.

XRAYS are used to diagnose
(1) Extent of bone loss associated with PERIODONTAL DISEASE
(2) Interproximal caries- decay in between the teeth
(3) Pathology of pulp
(4) Integrity of root canal fillings
(5) Verify tooth or root structure
(6) Supernumerary teeth, impacted teeth
(7) Pathologic root absorption
(8) Third molar location and position
(9) Bone pathology
(10) Need for interceptive orthopedic/orthodontic treatment
(11) What is normal for you. This will become important if you ever have trauma to your face and teeth due to an auto/bike accident or sports injury for example.

Current x-rays will be necessary before any diagnosis can be finalized.

Radiation exposure
This office uses digital x-rays. According to a UCLA study, the amount of exposure from a FMX (18 films) is equivalent to being out in the sun for 4 days. ***Our office takes the minimum number of x-rays to allow us to do a thorough exam and treatment for each patient.***

Females: Regarding Possibility of Pregnancy
PLEASE LET OUR OFFICE KNOW IF YOU ARE PREGNANT, POSSIBLY MIGHT BE OR ARE TRYING TO GET PREGNANT.
X-rays will be avoided unless it is an emergency. All pregnant women will be asked to have a medical release for x-ray (if absolutely necessary) and/or treatment on file from their OB Gyn.

Patient Consent to X-Ray for the length of my care with Dr. Nikolay Sky/Dr. Zoya Sky
I understand that prior to my dental treatment a thorough examination by the doctor is required. A necessary part of this examination is availability of dental x-rays. I understand that insurance companies may or may not reimburse me for the x-rays taken. I also understand that I will not be able to receive certain treatment without proper x-rays.

After thorough examination, the recommended treatment and my financial responsibility will be explained to me**.**
I understand that by signing this consent I am in no way obligated to any treatment. I also acknowledge that during treatment it may be necessary to change or add procedures because of conditions found during treatment that were not discovered during examination. For example, a root canal therapy following routine restorative procedure may be required.

Signed _____ Date_____

If Patient is a Minor

I am the parent or legal representative of who is a minor, years of age. I authorize the performance of diagnostic x-ray of this minor which Dr. Nikolay Sky/ Dr. Zoya Sky may consider necessary or advisable.

Signed _____ Date_____

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LATE CANCELLATION AND MISSED APPOINTMENT POLICY

Thank you for choosing Light Breeze Dental. Our office is dedicated to providing all our patients with the most thorough and comfortable comprehensive dental care available. We know that efficient scheduling is an important part of the dental office experience. We appreciate your respect for our daily schedule which allows our staff to be on time for you. We will always respect your time.

To enable us to provide efficient care we ask for your cooperation with the following guidelines:

1. **On time arrival**
   Please, arrive 15 minutes before your appointment time to complete any registration process, insurance updates, or medical history updates.

2. **Late arrival**
   If you are an established patient and you arrive 15 minutes late or more, we reserve the right to reschedule the appointment unless the dentist's schedule can still accommodate you. Priority will be given to the patients who arrive on time and you may have to be seen in between them. This may mean you will have a considerable wait. If this is not convenient to you, you may choose to reschedule. Late arrivals will cause a delay in seeing patients who are on time and inconvenience everyone.
   If you find you are running late, we recommend you call our office to determine if we can hold your appointment.

3. **Rescheduling**
   We require a **24-hour notice** to reschedule any appointment. You must contact our office to do so. Your treatment time is very important and valuable to us, and so is the time of our other patients in need of appointment.

4. **Missed Appointments**
   Your treatment time is reserved and tailored especially for you. We reserve the right to charge a fee of **$50** for patients who miss or cancel their appointment **without 24-hour notice**. This fee is not payable by any insurance company and therefore will be due before future services are rendered.

   We feel that these guidelines are reasonable in relation to the services we provide. We do understand that circumstances occur that will require our consideration.
   We welcome any questions.

Patient or Guardian Signature_____Date_____

Print name_____

Light Breeze Dental

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WRITTEN FINANCIAL POLICY

Thank you for choosing Light Breeze Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

- Cash, Visa, MasterCard, American Express or Discover Card
- Convenient Monthly Payment Options from CareCredit Healthcare Credit Card (OAC)
  - Allow you to pay over time
  - No annual fees or pre-payment penalties

Please note:
Light Breeze Dental requires payment for services at the time services are rendered unless prior arrangements have been made. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case. For plans requiring multiple appointments, alternative payment arrangements may be provided.

For Patients With Dental Insurance: Please understand that your insurance coverage is based on a contract among you, your employer, and the insurance company. We are not a party to that contract and there is nothing we can do regarding the coverage provided; as dental health care providers our relationship is with you.

Because insurance policies vary, **we can only estimate your coverage in good faith but cannot guarantee coverage** due to the complexities of insurance contracts, their unforeseen limitations, and exclusions.

The ultimate responsibility for payment always rests with the patient. As a courtesy, we will bill your insurance company for its share of the charges you incur. Your share of the bill (your copay) is due at the time of service. In the event that your insurance company determines that any service you received is "not covered", you are responsible for the complete fee. We will bill insurance companies for services and allow them 60 days to render payment. After 60 days, you are responsible for the entire balance, paid-in-full.

Minor Patients: Please plan to be present at appointments with your child under 18. If you cannot be there, please make prior arrangements with our staff. The parent accompanying the minor child is responsible for payment. In the case of a divorce, regardless of decree, the parent who brings the child and has signed the financial agreement is responsible to pay for the child's services. We are unable to bill separate parties; therefore parents can work out these details.

Your treatment time is reserved and tailored especially for you. We reserve the right to charge a fee of $50 for patients who miss or cancel their appointment without 24-hour notice. This fee is not payable by any insurance company and therefore will be due before future services are rendered.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

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HIPAA PRIVACY POLICY PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (i.e. my insurance company)
- The day to day healthcare operation of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at nm ay time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to theses requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name_____

Relationship to Patient_____

Signature_____

Date_____