Dr. Jack Ringer
Advanced Smile Design

VICE PRESIDENT & ACCREDITED MEMBER
AACD
American Academy of Cosmetic Dentistry®

# Welcome

On behalf of me and my staff, welcome to my office!

I opened my practice in Anaheim Hills in 1981. My practice philosophy is focused on
providing all family members contemporary preventive dental care with an emphasis on cosmetics. I've structured the practice with individual operatory rooms equipped with
the latest equipment and modern decor allowing for a high-tech, discreet and comfortable dental experience.

Since I am a solo practitioner and not contracted by any third party insurance, I am able to provide a true ongoing one-on-one dental relationship
with my patients.

My staff is highly trained and licensed with a total commitment to assisting our patients with any and all their dental needs.

Our office hours are Monday through Friday, 8:00 am to 5:00 pm and Saturday from 9:00 am to 1:00 pm.
You can also visit our website at www.dentalcosmetics.com.

As I live nearby, I am available for most dental emergencies. On my days off, an experienced dentist will be on call.

Please read and complete the attached forms and bring them
to your appointment.

We look forward to meeting you!

Sincerely,

_____

Dr. Jack Ringer

5765 East Santa Ana Canyon Road, Suite A, Anaheim Hills, California 92807
(714) 97 - ite: dentalcosmetics.com • - il: info@dentalcosmetics.com

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# Personalized Esthetic Evaluation

Patient Name: _____ Date: _____

Please answer the following questions that are specifically designed to aid our diagnosis and treatment of your esthetic needs:

| | YES | NO |
|---|---|---|
| 1. Do you dislike the color of your teeth? | ❑ | ❑ |
| 2. Do you have spaces between your teeth? | ❑ | ❑ |
| 3. Do you have chips or uneven edges on your teeth? | ❑ | ❑ |
| 4. Do you have any dark fillings visible? | ❑ | ❑ |
| 5. Are your teeth too short? | ❑ | ❑ |
| 6. Are your teeth too long? | ❑ | ❑ |
| 7. Are your teeth too crowded? | ❑ | ❑ |
| 8. Do your teeth feel "notched" at the gum line? | ❑ | ❑ |
| 9. Do your gums show when you are smiling? | ❑ | ❑ |
| 10. Do your gums feel unhealthy? | ❑ | ❑ |
| 11. Do your gums feel irregular in contour? | ❑ | ❑ |
| 12. Have you ever had orthodontic treatment? | ❑ | ❑ |
| 13. Are you satisfied with your facial appearance ? | ❑ | ❑ |

If not, why?_____

_____

14. If your smile were improved, would you feel more satisfied? . . . . . .

In general, how would you improve your smile?

_____

_____

Comments:

_____

_____

_____

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## Cancellation Policy

We require 48 hours notice if you are unable to keep an appointment.
You will be billed for the time reserved if we are unable to fill your appointed time.
Thank you for your cooperation.

I have read and understand the Cancellation Policy.

_____ Date: _____Relationship to patient: _____
Signature of patient or guardian

## Dental Materials Fact Sheet

I have received a copy of the Dental Materials Fact Sheet as required by law.

_____ Date: _____Relationship to patient: _____
Signature of patient or guardian

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# Medical History

Name: _____ Birth Date: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Work Phone: (  ) _____ Home Phone: (  ) _____ Cell Phone: (  ) _____

E-Mail Address: _____ Social Security #: _____

Major dental problem or reason for coming: _____

Physician's Name (Internist): _____

## Please describe your general health.

| | YES | NO |
|---|---|---|
| Have you been instructed to or have the need to be pre-medicated for any dental procedure? | ❑ | ❑ |
| Have you ever had any artificial joint replacement? | ❑ | ❑ |
| Have you had an unexplained gain or loss of weight (past 6 months)? How much? _____ | ❑ | ❑ |
| Do you smoke or use tobacco? If yes, how much? _____ | ❑ | ❑ |
| Have you ever been treated for cancer? | ❑ | ❑ |
| Have you ever had radiation treatment? | ❑ | ❑ |
| Do you have a poor appetite? | ❑ | ❑ |
| Do you feel that you are currently more tired than usual? | ❑ | ❑ |
| Do you have any body aches or pains? | ❑ | ❑ |
| Do you have night sweats or recurring fever? | ❑ | ❑ |
| Have you ever used intravenous drugs? | ❑ | ❑ |
| Have you used cocaine or "crack" within the last 6 months? | ❑ | ❑ |
| Do you actively engage in high risk behavior for infectious diseases (e.g. AIDS)? | ❑ | ❑ |

| HEAD AND NECK | YES | NO |
|---|---|---|
| Recurrent headaches | ❑ | ❑ |
| Glaucoma/eye disease | ❑ | ❑ |
| Recurrent earaches/hearing problems | ❑ | ❑ |
| Chronic sinusitis/post-nasal discharge | ❑ | ❑ |
| Recent difficulty swallowing | ❑ | ❑ |
| Persistent sore throat and hoarseness | ❑ | ❑ |
| Swollen neck glands | ❑ | ❑ |
| Recurrent neckache or neck pain | ❑ | ❑ |
| Injury to head, neck, jaw, teeth | ❑ | ❑ |

| RESPIRATORY | | |
|---|---|---|
| Breathing problems | ❑ | ❑ |
| Asthma or emphysema | ❑ | ❑ |
| Tuberculosis or a persistent cough | ❑ | ❑ |
| Coughing up blood | ❑ | ❑ |
| Pneumonia | ❑ | ❑ |

| ALLERGIES | | |
|---|---|---|
| Have you been allergic or had a reaction to: | | |
| Penicillin | ❑ | ❑ |
| Sulfa drugs | ❑ | ❑ |
| Dental anesthetics | ❑ | ❑ |
| Metals (rings/earrings) | ❑ | ❑ |
| Other (specify)_____ | | |

| NEUROMUSCULAR SYSTEM | YES | NO |
|---|---|---|
| Fainting spells or loss of consciousness | ❑ | ❑ |
| Seizures | ❑ | ❑ |
| Numbness, tingling, or paralysis | ❑ | ❑ |
| Recurrent backaches | ❑ | ❑ |
| Problem/walking, balance, dizziness | ❑ | ❑ |
| Persistent stiffness or painful joints | ❑ | ❑ |
| Artificial bone or joint implants | ❑ | ❑ |
| Recent or unusual headaches | ❑ | ❑ |

| CARDIOVASCULAR | | |
|---|---|---|
| High blood pressure | ❑ | ❑ |
| Difficulty breathing upon swallowing | ❑ | ❑ |
| Difficulty breathing when sleeping without extra pillows | ❑ | ❑ |
| Irregular or rapid heart beats | ❑ | ❑ |
| Chest pain due to physical exertion | ❑ | ❑ |
| Chest pain when upset | ❑ | ❑ |
| Rheumatic heart disease or fever | ❑ | ❑ |
| Congenital heart disease/heart murmur | ❑ | ❑ |
| Cardiac or vascular surgery | ❑ | ❑ |
| An artificial heart valve | ❑ | ❑ |
| Heart attack or other heart problem | ❑ | ❑ |
| A stroke | ❑ | ❑ |

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# Medical History Page 2

| DENTAL | YES | NO |
|---|---|---|
| Chronic face pain | ❑ | ❑ |
| Clicking/popping jaw | ❑ | ❑ |
| Difficulty opening or closing jaw | ❑ | ❑ |
| Unable to chew food well | ❑ | ❑ |
| Blisters/sores on lips or mouth | ❑ | ❑ |
| Unpleasant taste/bad breath | ❑ | ❑ |
| Burning tongue/lips | ❑ | ❑ |
| Swelling/lumps in mouth | ❑ | ❑ |
| Bleeding or infected gums | ❑ | ❑ |
| Loose teeth | ❑ | ❑ |
| Pain when chewing or opening mouth | ❑ | ❑ |
| Food catches between teeth | ❑ | ❑ |
| Recent toothache/sensitivity | ❑ | ❑ |
| Uncomfortable bite | ❑ | ❑ |
| Recent need to chew on one side | ❑ | ❑ |
| Clenching/grinding | ❑ | ❑ |
| Your bite adjusted | ❑ | ❑ |
| Bite appliance (TMJ splint) | ❑ | ❑ |
| Gum treatment or surgery | ❑ | ❑ |
| Orthodontic Treatment (braces) | ❑ | ❑ |

| GASTROINTESTINAL/URINARY | YES | NO |
|---|---|---|
| Persistent diarrhea/odd colored stools | ❑ | ❑ |
| Colitis or ulcers | ❑ | ❑ |
| Unexplained vomiting/frequent nausea | ❑ | ❑ |
| Alcoholic liver disease | ❑ | ❑ |
| Hepatitis or other liver disease | ❑ | ❑ |
| Jaundice (yellow skin or eyes) | ❑ | ❑ |
| Urinate more than once a night | ❑ | ❑ |
| Kidney disease/renal dialysis | ❑ | ❑ |
| A kidney transplant | ❑ | ❑ |
| Any urinary infection | ❑ | ❑ |
| Syphilis | ❑ | ❑ |
| Gonorrhea | ❑ | ❑ |
| Any other sexually transmitted disease | ❑ | ❑ |

| BLOOD/URINE | YES | NO |
|---|---|---|
| Bruise easily/bleed excessively | ❑ | ❑ |
| A blood transfusion | ❑ | ❑ |
| Anemia | ❑ | ❑ |
| Leukemia (cancer of the blood) | ❑ | ❑ |
| Diabetes or been frequently thirsty | ❑ | ❑ |
| Thyroid or adrenal gland disease | ❑ | ❑ |
| AIDS or ARC (AIDS Related Complex) | ❑ | ❑ |
| Positive blood test for HIV antibodies | ❑ | ❑ |
| Skin blotches or rash | ❑ | ❑ |
| Rheumatoid arthritis | ❑ | ❑ |
| Chronic itching | ❑ | ❑ |

| WOMEN ONLY | | |
|---|---|---|
| Do you menstruate regularly? | ❑ | ❑ |
| Do you flow heavily? | ❑ | ❑ |
| Are you pregnant? | ❑ | ❑ |
| If so, please give due date_____ | ❑ | ❑ |
| Are you in or have you passed through menopause (change of life)? | ❑ | ❑ |
| Are you taking hormones | ❑ | ❑ |
| Are you taking birth control pills? | ❑ | ❑ |

FAMILY HISTORY

Has anyone in your family (grandparent, parent, sibling, child) ever had:

| | | |
|---|---|---|
| Bleeding disorder | ❑ | ❑ |
| Heart disease | ❑ | ❑ |
| Mental/emotional disorder | ❑ | ❑ |
| Cancer | ❑ | ❑ |
| Tuberculosis | ❑ | ❑ |
| Diabetes | ❑ | ❑ |
| Genetic diseases/illnesses (specify)_____ | ❑ | ❑ |

_____

| BEHAVIORAL | YES | NO |
|---|---|---|
| Are you available and able to sit for a three-hour dental appointment? | ❑ | ❑ |
| Are there some aspects of the appearance of your teeth and jaw that need to be changed? | ❑ | ❑ |
| Do you often feel depressed or moody? | ❑ | ❑ |
| Do you often feel anxious or nervous? | ❑ | ❑ |
| Have you ever had psychiatric or psychological counseling? | ❑ | ❑ |
| Did you ever avoid a dental appointment because you were frightened? | ❑ | ❑ |
| Do you ever feel uncomfortable asking questions of doctors? | ❑ | ❑ |

List all prescription and non-prescription drugs (including aspirin) taken in the last 6 months:

| Name | Dosage | Name | Dosage |
|---|---|---|---|
| 1. | | 3. | |
| 2. | | 4. | |

List all hospitalizations and emergency room visits (include dates and reasons):

1. _____ 3. _____
2. _____ 4. _____

Have you been dissatisfied with previous dental treatment? ❑ YES ❑ NO

If, yes, please describe: _____

_____

I have read and understand the above questionnaire. To the best of my knowledge, all the preceding answers are true and correct.

Signed: _____ Date: _____

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# Office Financial Policy

Dr.Ringer and staff are committed to providing you with the best possible care. As part of this commitment we are available to discuss our professional fees during regular office hours. We feel that a clear understanding of our financial policy is most important in our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibilities.

Full payment for your office visit is due at time of service. We accept cash, check, MasterCard, Visa, Discover and American Express. We also work with two finance plan companies -Carecredit and Dental Fee Plan.

When dental insurance in America began 25-30 years ago, the benefits level compared to the cost of dentistry was very favorable. Consequently, the patient could receive a substantial amount of subsidized dentistry yearly. During these 30 years, the cost of dentistry has increased 300 - 400% due to inflation and greatly improved materials. Unfortunately, the amount of insurance benefits has increased very little and you, the patient, are receiving only 25 - 35% of the insurance coverage of 25 years ago.

This reduced coverage has forced many dentists who rely heavily on insurance to compromise service and quality to keep fees low. Many insurance companies even dictate the dentist's fees. Ultimately, you the patient may get a service that is less than optimal.

Dr. Ringer refuses to compromise service and quality for any reason. Consequently, we view insurance as financial assistance to our patients and not the dictating force. Thus, we have the following policy relative to dental insurance.

Insurance Policy:

1. We promise to make every effort to maximize your insurance reimbursement.
2. The patient is personally responsible for all fees.
3. By working together as a patient-dentist team, maximum insurance benefits will be achieved without compromising your quality of care.

## Insurance Information

Primary:

Name of Insured: _____ Is insured a patient? ❑ Yes ❑ No

Insured's Birth Date: _____ ID#: _____ Group#: _____

Insured's Address: _____

Insured's Employer Name: _____

Employer's Address: _____

Patient's relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Insurance Plan Name and Address: _____

_____

Secondary:

Name of Insured: _____ Is insured a patient? ❑ Yes ❑ No

Insured's Birth Date: _____ ID#: _____ Group#: _____

Insured's Address: _____

Insured's Employer Name: _____

Employer's Address: _____

Patient's relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Insurance Plan Name and Address: _____

_____

Insured Signature: _____ Date: _____

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# Patient Information Sheet

Date of Birth: _____

Last Name:_____First Name: _____Middle Name:_____

Address: _____ City:_____ State: _____ Zip:_____

Home Phone: (  ) _____Work Phone: (  ) _____ Cell Phone: {  } _____

E-Mail Address: {  } _____Driver's License: _____ Social Security #: _____

Bank: _____ Address or Branch:_____

Major Credit Card #: _____

Nearest Relative: _____ Phone: (  ) _____

## Spouse or Responsible Party Information

The following is for: ❑ the patient's spouse ❑ the person responsible for payment

Name: _____

Social Security #: _____ Birth Date: _____

Phone (Home) _____(Work):_____(Cell):_____Ext. _____ Best time to call: _____

Address: _____

Street Apartment #

City State Zip Code

## Employment Information

The following is for: ❑ the patient's spouse ❑ the person responsible for payment

Employer name:_____Occupation:_____

Address: _____

Street City State Zip Code

## Referral Information

Whom may we thank for referring you to our practice?

❑ Another Patient ❑ Dental Office ❑ Newspaper ❑ School ❑ Work ❑ Yellow Pages ❑ Web site

Name of person, office, newspaper, school or web site referring you to our practice:

_____

## Consent for Services

As a condition of your treatment by this office, payment at the time of service is required. If payment arrangements are necessary, outside funding is available. This type of financial arrangement must be made in advance, prior to service. Cash, Check and Credit Cards are accepted.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies. However, the dental office can not render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request by the Doctor, I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee at the time said services are rendered. I further agree that the reasonable value of said services shall be billed unless objected to, by me, in writing within the time for payment thereof. I further agree that a waiver of any breach of any time or condition thereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable costs and attorney fees if suit be instituted thereunder.

I grant my permission to you and your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

_____Date:_____ Relationship to Patient:_____

Signature of patient, parent or guardian

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# Photo Release Form

The following person, by signing this form, releases all claims and rights to their photo, video, likeness and name for the expressed use by Dr. Jack Ringer.

No compensation of any kind will be provided for the release of these rights and claims.

Dr. Jack Ringer reserves the right to change, alter and/or delete any part of these photos or likenesses for the expressed use by Dr. Jack Ringer.

❑ The following person is over 21 years of age.

❑ The following person is under 21 years of age.

Please print the name of the adult (parent or guardian) signer as well as the name of the minor in question.

**Agree:**

Print Name:_____ Date: _____

Name of Minor:_____

Signature: _____

**Disagree:**

Print Name:_____ Date: _____

Name of Minor:_____

Signature: _____

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# Sleep Disorder Questionnaire

Name: _____ Height: _____

EMail: _____ Weight: _____

Gender: M ☐ F ☐ DOB: _____

- OVER 18 MILLION AMERICANS SUFFER FROM SLEEP APNEA
- PEOPLE WITH SLEEP APNEA ARE 3 TIMES MORE LIKELY TO BE INVOLVED IN MOTOR VEHICLE ACCIDENTS
- 90% OF SLEEP APNEA PATIENTS HAVE NOT BEEN DIAGNOSED

| | YES | NO |
|---|---|---|
| Do you snore? | ❑ | ❑ |
| Do you have high blood pressure? | ❑ | ❑ |
| Have you gained weight and find it difficult to lose? | ❑ | ❑ |
| Do you have unexplained awakenings from sleep? | ❑ | ❑ |
| Do you lack energy upon waking in the morning? | ❑ | ❑ |
| Do you often lay in bed unable to fall asleep? | ❑ | ❑ |
| Do you wake up during the night, unable to fall back asleep? | ❑ | ❑ |
| Do you find it difficult to stay awake during the day? | ❑ | ❑ |

* * * *If you answered YES to any of the above Questions, please consult with your doctor. * * * *

## Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

Please answer with a 0 to 3

**0 = Would never doze** **1 = Slight chance of dozing**
**2 = Moderate chance of dozing** **3 = High chance of dozing**

| | | | |
|---|---|---|---|
| Sitting and reading | _____ | Watching TV | _____ |
| Sitting inactive in a public place | _____ | As a passenger in a car for an hour without a break | _____ |
| Lying down to rest in the afternoon | _____ | Sitting and talking to someone | _____ |
| Sitting quietly after lunch without alcohol | _____ | In a car while stopped for a few minutes in traffic | _____ |
| | | Total Score | _____ |

Physician's Name: _____

Physician's Phone # _____ FAX # _____

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