

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 operator 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

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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have spaces between your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have chips or uneven edges on your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have any dark fillings visible? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are your teeth too short? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are your teeth too long? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are your teeth too crowded? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do your teeth feel "notched" at the gum line? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do your gums show when you are smiling? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do your gums feel unhealthy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do your gums feel irregular in contour? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever had orthodontic treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Are you satisfied with your facial appearance ? | <input type="checkbox"/> | <input type="checkbox"/> |

If not, why? _____

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

In general, how would you improve your smile?

Comments:

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

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?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any artificial joint replacement?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had an unexplained gain or loss of weight (past 6 months)? How much? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke or use tobacco? If yes, how much? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been treated for cancer?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had radiation treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a poor appetite?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel that you are currently more tired than usual?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any body aches or pains?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have night sweats or recurring fever?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever used intravenous drugs?	<input type="checkbox"/>	<input type="checkbox"/>
Have you used cocaine or "crack" within the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
Do you actively engage in high risk behavior for infectious diseases (e.g. AIDS)?	<input type="checkbox"/>	<input type="checkbox"/>

HEAD AND NECK

	YES	NO
Recurrent headaches	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma/eye disease	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent earaches/hearing problems	<input type="checkbox"/>	<input type="checkbox"/>
Chronic sinusitis/post-nasal discharge	<input type="checkbox"/>	<input type="checkbox"/>
Recent difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Persistent sore throat and hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
Swollen neck glands	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent neckache or neck pain	<input type="checkbox"/>	<input type="checkbox"/>
Injury to head, neck, jaw, teeth	<input type="checkbox"/>	<input type="checkbox"/>

NEUROMUSCULAR SYSTEM

	YES	NO
Fainting spells or loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Numbness, tingling, or paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent backaches	<input type="checkbox"/>	<input type="checkbox"/>
Problem/walking, balance, dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Persistent stiffness or painful joints	<input type="checkbox"/>	<input type="checkbox"/>
Artificial bone or joint implants	<input type="checkbox"/>	<input type="checkbox"/>
Recent or unusual headaches	<input type="checkbox"/>	<input type="checkbox"/>

RESPIRATORY

	YES	NO
Breathing problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma or emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis or a persistent cough	<input type="checkbox"/>	<input type="checkbox"/>
Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>

CARDIOVASCULAR

	YES	NO
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty breathing upon swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty breathing when sleeping without extra pillows	<input type="checkbox"/>	<input type="checkbox"/>
Irregular or rapid heart beats	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain due to physical exertion	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain when upset	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic heart disease or fever	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease/heart murmur	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac or vascular surgery	<input type="checkbox"/>	<input type="checkbox"/>
An artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack or other heart problem	<input type="checkbox"/>	<input type="checkbox"/>
A stroke	<input type="checkbox"/>	<input type="checkbox"/>

ALLERGIES

Have you been allergic or had a reaction to:

Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>
Dental anesthetics	<input type="checkbox"/>	<input type="checkbox"/>
Metals (rings/earrings)	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify) _____		

Medical History Page 2

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

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

GASTROINTESTINAL/URINARY

Persistent diarrhea/odd colored stools	<input type="checkbox"/>	<input type="checkbox"/>
Colitis or ulcers.	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained vomiting/frequent nausea	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholic liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis or other liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice (yellow skin or eyes)	<input type="checkbox"/>	<input type="checkbox"/>
Urinate more than once a night.	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease/renal dialysis.	<input type="checkbox"/>	<input type="checkbox"/>
A kidney transplant.	<input type="checkbox"/>	<input type="checkbox"/>
Any urinary infection.	<input type="checkbox"/>	<input type="checkbox"/>
Syphilis.	<input type="checkbox"/>	<input type="checkbox"/>
Gonorrhea.	<input type="checkbox"/>	<input type="checkbox"/>
Any other sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>

WOMEN ONLY

Do you menstruate regularly?.	<input type="checkbox"/>	<input type="checkbox"/>
Do you flow heavily?	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
If so, please give due date_____	<input type="checkbox"/>	<input type="checkbox"/>
Are you in or have you passed through menopause (change of life)?	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking hormones	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>

FAMILY HISTORY

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

Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease.	<input type="checkbox"/>	<input type="checkbox"/>
Mental/emotional disorder	<input type="checkbox"/>	<input type="checkbox"/>
Cancer.	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.	<input type="checkbox"/>	<input type="checkbox"/>
Genetic diseases/illnesses (specify)_____	<input type="checkbox"/>	<input type="checkbox"/>

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

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: _____

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: _____

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

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: _____

