KATHLEEN A. GORDON, DDS
Family & Cosmetic Dentistry
A Beautiful Smile Starts Here®

On behalf of the entire team at the Dental Office of Kathleen A. Gordon, D.D.S., let me welcome you to our practice. We are grateful that you have chosen us to meet your dental needs, and trust that you will find your experience in our beautiful and modern office to be pleasant, professional and extraordinary.

You may discover that we are different from the average dental practice. When you visit our office you will find a unique and relaxing environment. Our team is friendly, compassionate and attentive. All of our treatment is designed to be comfortable, long lasting and to exceed all your expectations. We use the latest in proven technology our profession has to offer.

In order to better serve you, we have attached in this Welcome Packet several important documents that will assist us in making your transition to our office as smooth as possible. **Please read and complete each one** carefully so that you can become familiar with our practice philosophy and policies. We are happy to answer questions you may have at any time.

Be sure to visit our website at www.kagordondds.com. We look forward to serving all your dental needs for you and your family.

Respectfully,

Kathleen A. Gordon, D.D.S.

KATHLEEN A. GORDON, DDS
Family & Cosmetic Dentistry
A Beautiful Smile Starts Here®

PATIENT REGISTRATION FORM

Thank you for selecting our dental office. To help us meet all of your health care needs, please complete the following confidential information on this form as accurately as possible.

Where Beautiful Smiles Begin.

I PATIENT INFORMATION

Date: ____________ This appointment is for: ☐ Self ☐ Dependent ☐ Other Gender: ☐ Male ☐ Female

Patient Name: ________________________ (Last) ____________________ (First) ______ (M.I.) Prefers to be called by: _________________

Social Security No: ____________________ Date of Birth: ____________ Age: _____ Marital Status: ______________

Address: ____ ___________________ (City) ________ (State) _________________ (Zip)

Employer: ____ Occupation: ______________________________________

Previous Dentist: ____________________________________ Previous Dentist Phone: ____________________________

Is another member of your family, or relative, a patient at our office? ☐ Yes ☐ No

If Yes: Name: __________________________________ Relationship: ______________________________________

You were referred to us by? ____

CONTACT INFORMATION

Home Phone: _____________________ Work Phone: ____________________ Cell Phone:* _____________________

Email Address:* ____

*Note: For the best possible service to our patients, our office requests either your email address and/or your cell phone for text messaging so that we may contact you to provide you with future appointment reminders, etc.

In the event of an **emergency**, who should we contact: Name: _______________________________________

Relationship: ______________________ Contact Phone: __________________ Work Phone: ____________________

II RESPONSIBLE PARTY

Name: ____________________________ Social Security No: __________________ Relationship: _________________

Contact Phone: ___________________ Work Phone: _______________________ Date of Birth: _________________

Employer: ____ Occupation: ______________________________________

4515 Central Avenue, Suite 103 • Riverside, CA 92506 • (951) 682-0042
www.kagordondds.com

III SUBSCRIBER'S INSURANCE INFORMATION

Subscriber's Name: ________________________ Group ID#: ________________ Insurance ID#: _________________

Primary Insurance Company Name and Telephone #: ____

Subscriber's Date of Birth: ____________ SSN#: _________________ Relationship to Patient: ___________________

Secondary Insurance Company Name and Telephone #: ____

Subscriber's Name: ________________________ Group ID#: ________________ Insurance ID#: _________________

Subscriber's Date of Birth: ____________ SSN#: _________________ Relationship to Patient: ___________________

IV NOTICES

CONSENT FOR TREATMENT

Please initial below:

______ I assign the **Dental Office of Kathleen A Gordon, D.D.S.** all my right, title, and interest in and to any and all dental benefits otherwise payable to me for oral health treatment rendered by the assignee. I acknowledge that billing my insurance company for the services rendered is a courtesy done by the **Dental Office of Kathleen A Gordon, D.D.S.** I am still responsible for paying the above-referenced dentist if the relevant insurer or payer does not pay the dentist in full.

______ If I must change my appointment, I must notify the **Dental Office of Kathleen A Gordon, D.D.S.** at least 48 hours (except for emergencies), or a $50.00 fee will be assessed.

______ I hereby authorize doctor or designated staff to take X-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of ______________________________ dental needs.
Name of Patient

______ Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

______ I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

______ I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outling the protection of my personal health information is available.

______ I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

_____________________________________ ___________________ _____________________________________
Patient Signature **Date:** **Witness**

Parent/Responsible Party's Signature: ______________________________ **Relationship to Patient:** ___________________

KATHLEEN A. GORDON, DDS
Family & Cosmetic Dentistry
A Beautiful Smile Starts Here®

CONFIDENTIAL DENTAL HISTORY

Patient Name: ____________________ **Date of Birth:** __________ **Account #:** __________

Medical Condition Alert: ____________________

Welcome to our office! So that our office may provide you with the best possible care, please complete both the dental/ medical history forms. **All information provided is completely confidential.**

What is the reason for your visit today? ____________________

Date of last dental visit: __________ Last dental cleaning: __________ Last full mouth X-rays: __________

How often do you have dental examinations? ____________________

How often do you brush your teeth? __________ How often do you floss? __________

Do you have any dental problems now? ☐ Yes ☐ No

If yes, please describe: ____________________

ARE ANY OF YOUR TEETH SENSITIVE TO:

- Hot or Cold ☐ Yes ☐ No
- Sweets? ☐ Yes ☐ No
- Biting or Chewing? ☐ Yes ☐ No
- Have you noticed mouth odors or bad tastes? ☐ Yes ☐ No
- Do you frequently get cold sores, blisters or any other oral lesions? ☐ Yes ☐ No
- Do your gums bleed or hurt ☐ Yes ☐ No
- Have you noticed loose teeth or change in your bite? ☐ Yes ☐ No
- Have your parents experienced gum disease or tooth loss? ☐ Yes ☐ No
- Does food tend to become caught in-between your teeth? ☐ Yes ☐ No

  If yes, where: ____________________

DO YOU:

- Clench or grind your teeth while awake or asleep ☐ Yes ☐ No
- Bite your lips or cheeks regularly? ☐ Yes ☐ No
- Hold foreign objects with your teeth (Pencils, Nails, Fingernails, Pipe)? ☐ Yes ☐ No
- Smoke/Chew tabacco? ☐ Yes ☐ No

HAVE YOU EVER HAD:

- Orthodontic treatment? ☐ Yes ☐ No
- Oral Surgery? ☐ Yes ☐ No
- Periodontal treatment? ☐ Yes ☐ No
- Your teeth ground or the bite adjusted? ☐ Yes ☐ No
- A bite plate or mouth guard? ☐ Yes ☐ No
- Mouth breathing while awake or asleep? ☐ Yes ☐ No
- Have tired jaws, esp. in the morning? ☐ Yes ☐ No
- To take a pre-medication prior to receiving dental treatment? ☐ Yes ☐ No

HAVE YOU EVER HAD:

- Clicking or popping of the jaw? ☐ Yes ☐ No
- Pain (joint, ear, side of face)? ☐ Yes ☐ No
- Difficulty in chewing on either side of the mouth? ☐ Yes ☐ No
- Headaches, neck aches or shoulder aches? ☐ Yes ☐ No
- Sore muscles (neck, shoulders)? ☐ Yes ☐ No
- A serious injury of the mouth or head? ☐ Yes ☐ No

  If so, please describe (including the cause) ____________________

4515 Central Avenue, Suite 103 • Riverside, CA 92506 • (951) 682-0042
www.kagordondds.com

KATHLEEN A. GORDON, DDS
Family & Cosmetic Dentistry
A Beautiful Smile Starts Here®

CONFIDENTIAL HEALTH HISTORY

Patient Name: ______________________ **Date of Birth:** __________ **Account #:** __________

Medical Condition Alert: ______________________________

I SELECT APPROPRIATE YES or NO FOR EACH: (Note: Leave blank if you do not understand the question)

Is your general health good? ☐ Yes ☐ No
If No, explain: ______________________________

Has there been a change in your health within the last year? ☐ Yes ☐ No
If Yes, explain: ______________________________

Have you gone to the hospital or emergency room or had a serious illness in the last (3) years? ☐ Yes ☐ No
If Yes, explain: ______________________________

Are you currently being treated by a physician? ☐ Yes ☐ No
If Yes, explain: ______________________________

Date of last medical exam: __________ Reason for exam? ______________________________

Current Physician's Name: ______________________ Physician's Phone: __________

Have you taken any medication or drugs during the past two years? ☐ Yes ☐ No

Are you taking any medication or drugs currently, including regular doses of aspirin or over-the-counter herbal medicines? ☐ Yes ☐ No
If Yes, please list: ______________________________

4515 Central Avenue, Suite 103 • Riverside, CA 92506 • (951) 682-0042
www.kagordondds.com

II HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING?

- ☐ Yes ☐ No Heart disease or Heart surgery
- ☐ Yes ☐ No Family history of heart disease
- ☐ Yes ☐ No Heart attack
- ☐ Yes ☐ No Artificial joint
- ☐ Yes ☐ No Stomach problems or ulcers
- ☐ Yes ☐ No Heart defects
- ☐ Yes ☐ No Heart murmurs
- ☐ Yes ☐ No Rheumatic fever
- ☐ Yes ☐ No Skin disease
- ☐ Yes ☐ No Hardening of arteries
- ☐ Yes ☐ No High blood pressure
- ☐ Yes ☐ No Seizures
- ☐ Yes ☐ No Cosmetic surgery
- ☐ Yes ☐ No AIDS/HIV
- ☐ Yes ☐ No Surgeries
- ☐ Yes ☐ No Hospitalization
- ☐ Yes ☐ No Diabetes
- ☐ Yes ☐ No Family history of diabetes
- ☐ Yes ☐ No Tumors or cancer
- ☐ Yes ☐ No Chemotherapy
- ☐ Yes ☐ No Radiation
- ☐ Yes ☐ No Arthritis, rheumatism
- ☐ Yes ☐ No Emphysema or other lung disease
- ☐ Yes ☐ No Kidney or bladder disease
- ☐ Yes ☐ No Stroke
- ☐ Yes ☐ No Eating disorders

III ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?

- ☐ Yes ☐ No Aspirin
- ☐ Yes ☐ No Codeine
- ☐ Yes ☐ No Latex
- ☐ Yes ☐ No Local anesthetic
- ☐ Yes ☐ No Valium
- ☐ Yes ☐ No Demerol
- ☐ Yes ☐ No Penicillin
- ☐ Yes ☐ No Food
- ☐ Yes ☐ No Erythromycin
- ☐ Yes ☐ No Tetracycline
- ☐ Yes ☐ No Vicodin
- ☐ Yes ☐ No Percodan
- ☐ Yes ☐ No Nitrous oxide
- ☐ Yes ☐ No Metal
- ☐ Yes ☐ No Other: ____________________
- ☐ Yes ☐ No Other: ____________________
- ☐ Yes ☐ No Other: ____________________

IV WOMEN ONLY

Are you or could you be pregnant? ☐ Yes ☐ No If Yes, what month? __________

Are you nursing? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

V ALL PATIENTS

Do you have or have you had any other diseases or medical problems NOT listed on this form? ☐ Yes ☐ No

If Yes, please explain: ______________________________

Have you ever been pre-medicated for dental treatment? ☐ Yes ☐ No

If Yes, why? ______________________________

Have you ever taken Fen-Phen? ☐ Yes ☐ No If Yes, when: ______________________________

Is there any issue or condition that you would like to discuss with the dentist in private? ☐ Yes ☐ No

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: ______________________________ **Date:** ________________

Physician's Name: ______________________________ **Phone Number:** ________________

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

______________________________	________________	______________________________	________________
Signature of Patient (Parent/Guardian)	**Date:**	**Signature of Dentist**	**Date:**

4515 Central Avenue, Suite 103 • Riverside, CA 92506 • (951) 682-0042
www.kagordondds.com