

Corona Caring Dental

Dr. Lilliam E. Marrero-Lopez DMD General Dentist

Dr. Walter J. Snow-Noguera DMD Pediatric Dentist

Name _____ Social Security _____ Age _____

Date of Birth _____ Gender (Male) _____ (Female) _____

Minor of 21 year Age Patient's Legal Guardian Information below,

Mother Name's _____ **Father's Name** _____

Address _____ Address _____

City, state Zip code _____ City, State Zip Code _____

Social Security _____ **Social Security** _____

Date of Birth _____ Date of Birth _____

Place of Employment _____ Place of Employment _____

Work Phone Number _____ Work Phone Number _____

Dental Insurance (Yes or No) _____ Dental Insurance(Yes or No) _____

Group Name _____ Group Name _____

Group Number _____ Group Number _____

Marital Status _____ Number of Children _____

Ages _____

Where You Referred (Yes or No) _____ If Yes, By

Whom? _____

Close Relative (Name, Address, Phone Number)

Physician or Pediatrician Name/Address/Phone

Number _____

Medical History-----

(YES) (NO)

Are the patient in good Health-----

() ()

Has the patient had regular medical checkups? (Date of last visit)-----

() ()

Has the patient ever been hospitalized? If yes for what-----

() ()

(Minor of 21 Year old)

Do you consider your child to be

_____ Advanced in the learning process _____Progressing normal _____ Slow learner

Has your child been immunized for : (YES) (NO)

Ditherier, Whooping Cough (Peruses) and Tetanus ----- () ()

Polio----- () ()

Measles and German Measles (Rubella) ----- () ()

Has your Child had a DPT AND Polio Booter? ----- () ()

At 1-2----- () ()

At 3-4----- () ()

Diphtheria and Tetanus (Adult type) every 10 years thereafter---- () ()

Has your Child ever been allergic to anything? ----- () ()

If yes, what? _____

Is your child taking any medication now? If yes, what? ----- () ()

PATIENT INFORMATION & HEALTH HISTORY

Please check the proper bracket if now the patient has problems with any of the following:

Allergic to Penicillin () Diabetes () Tuberculosis ()

Mental disorder () Asthma () Cerebral Palsy ()

Heart () Cleft Palate () Excessive Bleeding ()

Kidney () Heart Murmur () Rheumatic Fever ()

Liver () Speech () Nervous disorders ()

Hay Fever () Seizures () Epilepsy ()

Dental history (minor than 21 years old)

Is this is your child first visit to the Dentist? ----- () ()

When was the last visit? _____

Will your child be a cooperative dental patient? ----- () ()

Does your child take fluoride or vitamins with fluoride----- () ()

If your child was bottle fed, at what age your child give it up completely? () ()

Does your child have any bed habits (thumb or finger sucking, lip biting) --- () ()

(YES) (NO)

Have there been any injuries to your teeth-----

() ()

Has the patient inherited any family dental characteristics? -----

() ()

Cavities	()	Teeth bumped	()
Toothache	()	Crooked Teeth	()
Teeth sensitive to sweet	()	Colored Teeth	()
Teeth sensitive to hot/ cold	()		

Please check the reason(s) for today's visit:

Decay	()	Behavior	()
Checkup	()	Physical/Mental Handica	()
Emergency	()	Orthodontics	()
Habit	()	Other	()

Permission is hereby granted to Corona Caring Dental and their staff to furnish any Insurance company obligated to me or any dependant, or any welfare or relief organization, or political subdivision to which I have applied or may applied or may subsequently apply for aid, any and all information with respect to any illness or injury, medical history, consultation or treatment

Signed_____Signed_____

MEDICAL HISTORY UPDATE

I have read my Medical History dated _____ and confirm that it adequately states past and present conditions.

PLEASE DATE AND SIGN

Date	Exceptions	Patient's Signature (Legal Guardian)	BP/ & P	Dr
_____	_____	None() _____		

CORONA CARING DENTAL GROUP, INC

Dr. Lilliam E. Marrero-Lopez DMD
Dr. Walter J. Snow-Noguera DMD

CONSENT FOR DENTAL TREATMENT

Patient's Name: _____ Date: _____

Patient's Birth Date : _____ Time: _____ AM
PM

1. I herby authorized Corona Caring Dental Group, Inc, and its employees, agents assistants to perform all dental procedures or course of procedures necessary to diagnose, treat, and care for the patient's dental needs.

If any unforeseen conditions arise during the course of the procedure, I request and authorize the aforementioned Dentist, and its employees, agents and assistants to perform or do whatever is clinically necessary to treat such unforeseen condition(s).

2. The purpose of these dental procedures or course of procedures are to diagnose and treat the patient's dental problems.

3. These dental procedures are expected to provide for the restoration and maintenance of good dental health.

However, I acknowledge and understand that these dental procedures or course do procedures do not always produce desired, expected or successful results that NO GUARANTEES can be made concerning the results of these procedures.

4. The reasonable known risks of these dental procedures or course of procedures are: allergies that may occur with the use of medications.

5. I acknowledge that full and complete disclosure of the information in this Consent Form has been made and all my questions asked about these procedures have been answered in a satisfactory matter.

Witness

Signature of Patient

Witness

Signature of Patient or Spouse, If available

If the patient lacks capacity to consent because of (Check); ___minor (under the age of 18); or ___physical or mental incompetence; or ___ under influence of alcohol, hallucinogens, or drugs (circle appropriate item); or ___ other, then the following must be sign.

Witness

Parent, if Patient a minor or legal guardian or other person authorize

Witness

Parent, if Patient a minor or legal guardian or other person authorize

CORONA CARING DENTAL
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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

July 1, 2008

Dear Patients

I acknowledge that the information of NOTICE OF PRACTICE is available in reception area and also given to me in case I wish to have it.

This notice of Practice explains in general how Hospitals, Medical offices and Dental Offices, set standards to protect patient privacy regarding records and electronics claims.

Sincerely

Dr. Lilliam E. Marrero-Lopez DMD

Dr. Walter J Snow-Noguera DMD

Patient Name _____

Address _____

Telephone _____

Date _____

Date of Birth of Patient _____