Welcome to our Practice

Today's Date 04/30/2022

PATIENT INFORMATION:

☑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name Jonathan M.I. ____ Last Name Kimber

Sex: ❑ Male ❑ Female Birth Date 06/15/1948 Age 73 Soc. Sec. # 070-54-8451 E-mail coonukimber@yahoo.com

Street 7127 Fasano Pl Apt. ____ City Rancho Cucamonga State CA Zip 91701

Home Tel.(562) 440-8594 Cell.(562) 449-8594 Have you ever been a patient of our practice? ❑ Yes ☑ No

Referred By ____ (FIRST NAME) ____ (LAST NAME) Has a family member ever been a patient of our practice? ❑ Yes ☑ No

Dentist Lila (FIRST NAME) Kakar (LAST NAME) Orthodontist ____ (FIRST NAME) ____ (LAST NAME) Medical Dr. Sandar (FIRST NAME) Win (LAST NAME)

Driver's Lic.# U5197748 Nearest relative not living with you Mildred (FIRST NAME) Kimber (LAST NAME) Tel.(909) 367-6237

Employer ____ Bus. Tel.(____) ____ Personal Payment Type: ❑ Cash ❑ Check ☑ Credit Card

In case of emergency, please contact Mildred Kimber Tel. (909) 367-6237 Relation Spouse

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

☑ Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other ____

Name Jonathan (FIRST NAME) Kimber (LAST NAME) S.S.# 070-54-8451 Birth Date 06/15/1948 Age 73

Tel.(562) 440-8594 Cell. (562) 449-8594 E-mail coonukimber@yahoo.com

Street 7127 Fasano Pl Apt. ____ City Rancho Cucamonga State CA Zip 91701

Driver's Lic.# U5197748 Employer ____ Bus. Tel.(____) ____

SPOUSE OR OTHER GUARANTOR INFORMATION: *(IF DIFFERENT FROM ABOVE)*

Name ____ (FIRST NAME) ____ (LAST NAME) Relation ____ S.S.# ____ Birth Date ____

Street ____ Apt. ____ City ____ State ____ Zip ____

Tel. (____) ____ Employer ____ Bus. Tel.(____) ____

INSURANCE INFORMATION:

Student: . . . . . ❑ Full Time ❑ Part Time ❑ Not . . . . . School Name and Address ____ (SCHOOL NAME) ____ (ADDRESS)

Marital Status: . ☑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated ____ (CITY) ____ (STATE) ____ (ZIP)

Employed: . . . . ❑ Full Time ❑ Part Time ☑ Retired ❑ Not . . . . . Do you belong to a PPO or HMO? ☑ Yes ❑ No

PRIMARY DENTAL INSURANCE COMPANY:

Employer N/A

Bus. Address ____ (ADDRESS) ____ (CITY) ____ (STATE) ____ (ZIP)

Bus. Tel.(____) ____ Plan UHC Dental Benefits

Ins. Co. Name AARP MedicareCompl I.D. # 6829651

Address P. O. Box 30776 (ADDRESS) Salt Lake City (CITY) UT (STATE) 84130 (ZIP)

Tel.(800) 822-5353 Group Name UHC Dental Benefits

Group # 3637 Insured Party Jonathan (FIRST NAME) Kimber (LAST NAME)

Relation self Birth Date 06/15/1948 Sex: ☑ M ❑ F

S.S. # 070-54-8451 Tel.(562) 440-8594

Address 7127 Fasano Pl (ADDRESS) Rancho Cucan (CITY) CA (STATE) 91701 (ZIP)

PRIMARY MEDICAL INSURANCE COMPANY:

Employer N/A

Bus. Address ____ (ADDRESS) ____ (CITY) ____ (STATE) ____ (ZIP)

Bus. Tel.(____) ____ Plan HMO

Ins. Co. Name UnitedHealthcare Denta I.D. # 6829651-01

Address P.O.Box 30968 (ADDRESS) Salt Lake City (CITY) UT (STATE) 84130 (ZIP)

Tel.(562) 440-8594 Group Name AARP Medical Advant

Group # HCFAZ9 Insured Party Jonathan (FIRST NAME) Kimber (LAST NAME)

Relation self Birth Date 06/15/1948 Sex: ☑ M ❑ F

S.S. # 070-54-8451 Tel.(888) 856-8297

Address 7127 Fasano Pl (ADDRESS) Rancho Cucan (CITY) CA (STATE) 91701 (ZIP)

SECONDARY DENTAL INSURANCE COMPANY:

Employer ____

Bus. Address ____ (ADDRESS) ____ (CITY) ____ (STATE) ____ (ZIP)

Bus. Tel.(____) ____ Plan ____

Ins. Co. Name ____ I.D. # ____

Address ____ (ADDRESS) ____ (CITY) ____ (STATE) ____ (ZIP)

Tel.(____) ____ Group Name ____

Group # ____ Insured Party Jonathan (FIRST NAME) Kimber (LAST NAME)

Relation ____ Birth Date 06/15/1948 Sex: ❑ M ❑ F

S.S. # 070-54-8451 Tel.(562) 440-8594

Address 7127 Fasano Pl (ADDRESS) Rancho Cucan (CITY) CA (STATE) 91701 (ZIP)

SECONDARY MEDICAL INSURANCE COMPANY:

Employer ____

Bus. Address ____ (ADDRESS) ____ (CITY) ____ (STATE) ____ (ZIP)

Bus. Tel.(____) ____ Plan ____

Ins. Co. Name ____ I.D. # ____

Address ____ (ADDRESS) ____ (CITY) ____ (STATE) ____ (ZIP)

Tel.(____) ____ Group Name ____

Group # ____ Insured Party Jonathan (FIRST NAME) Kimber (LAST NAME)

Relation ____ Birth Date 06/15/1948 Sex: ❑ M ❑ F

S.S. # 070-54-8451 Tel.(562) 440-8594

Address 7127 Fasano Pl (ADDRESS) Rancho Cucan (CITY) CA (STATE) 91701 (ZIP)

HEALTH HISTORY:

To our patients: *Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.*

Reason for today's office visit? Root Canal Treatment and Build-UP

		Yes	No
1.	***Height*** 5'10" ***Weight*** 220 Are you in good health?	☑	☐
2.	Have there been any changes in your general health in the past year?	☐	☑
3.	Are you under the care of a physician? ***Date of last visit*** 11/3/21	☐	☑
	If so, for what are you being treated? Yearly Physical		
4.	Have you had any illness, operation or been hospitalized in the past five years?	☑	☐
	If so, describe Kidney Stone Removal		
5.	Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?	☐	☑
	If so, describe where		
6.	Do you have a prosthetic joint / implant? ***If so, describe where***	☐	☑
7.	Have you had a heart valve replacement or vascular graft?	☐	☑
8.	Have you ever had general anesthesia?	☑	☐
9.	Have you, or a family member, had any unusual or serious reactions to general anesthesia?	☐	☑
10.	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☑

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
11. Rheumatic fever?		✔	
12. Damaged heart valves / mitral valve prolapse?		✔	
13. Heart murmur?		✔	
14. High blood pressure?		✔	
15. Low blood pressure?		✔	
16. Chest pain / angina?		✔	
17. Heart attack(s)?		✔	
18. Irregular heart beat?		✔	
19. Cardiac pacemaker?		✔	
20. Heart surgery?		✔	
21. Pneumonia, bronchitis, chronic cough?		✔	
22. Asthma?		✔	
23. Hay fever / sinus problems?		✔	
24. Snoring?	✔		
25. Sleep apnea / CPAP?		✔	
26. Difficult breathing / other lung trouble?		✔	
27. Tuberculosis?		✔	
28. Emphysema?		✔	
29. Do you smoke? If so, number of packs a day _____		✔	
30. Do you use chewing tobacco?		✔	
31. Blood transfusion?		✔	
32. Blood disorder such as anemia?		✔	
33. Bruise easily?		✔	
34. Bleeding tendency / abnormal bleed?		✔	
35. Hepatitis, jaundice, or liver disease?		✔	
36. Infectious mononucleosis?		✔	
37. Gallbladder trouble?		✔	

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
38. Fainting spells?		✔	
39. Convulsions / epilepsy?		✔	
40. Stroke?		✔	
41. Thyroid trouble?		✔	
42. Diabetes?		✔	
43. Low blood sugar?		✔	
44. Kidney trouble?		✔	
45. High cholesterol?	✔		
46. Are you on dialysis?		✔	
47. Swollen ankles / arthritis / joint disease?		✔	
48. Osteoporosis / osteopenia?		✔	
49. Osteonecrosis?		✔	
50. Stomach ulcers / acid reflux?		✔	
51. Contagious diseases?		✔	
52. Sexually transmitted diseases?		✔	
53. Problems with immune system? Possibly from medication / surgery, etc.		✔	
54. Delay in healing?		✔	
55. A tumor or growth?		✔	
56. Cancer / radiation therapy / chemotherapy?		✔	
57. Chronic fatigue / night sweats?		✔	
58. Are you on a diet?		✔	
59. A history of alcohol abuse?		✔	
60. A history of drug abuse?		✔	
61. Contact lenses?		✔	
62. Eye disease / glaucoma?		✔	
63. Mental health problems / anxiety / depression?		✔	
64. A removable dental appliance?		✔	
65. Pain or clicking of jaws when eating?		✔	

WOMEN ONLY: *(QUESTIONS 66–69)*

	Yes	No
66. Is there a possibility of pregnancy?	❑	❑
67. Expected delivery date? _____		
68. Are you nursing?	❑	❑
69. Are you taking birth control pills?	❑	❑

Note: *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding other methods of birth control.*

ARE YOU NOW TAKING:	YES	NO	NOTES
70. Any kind of medication, drug, pills?		✔	
71. Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Pradaxa, Fish oil)?		✔	
72. Have you ever taken diet pills?		✔	
73. Any natural product, herbal supplement or homeopathic remedy?	✔		
74. Are you taking, or have you ever taken, bone density meds. or bisphosphonates such as Fosamax, Boniva, Actonel, IV– Zometa, Aredia, Xgeva, Prolia, or Reclast in the past 12 years?		✔	

75. Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? If so, please list:

False

76. Please list any medications you are currently taking:

Medication	Dosage	Frequency

If you are having surgery **today**, have you had anything to eat or drink in the last 6 (six) hours? ❑ Yes ☑ No

Who is driving you home? self

Is there any condition concerning your health that the Doctor should be told about? ☑ Yes ❑ No – If Yes, describe

Take a lot to num me

Do you wish to speak to the Dr. privately about anything? ❑ Yes ☑ No

ARE YOU ALLERGIC TO, OR HAD A REACTION TO:	YES	NO	NOTES
77. Local anesthetic (numbing meds.)?		✔	
78. Penicillin?		✔	
79. Other antibiotics?		✔	
80. Sulfa drugs?		✔	
81. Sodium pentothal / Valium /other tranquilizers?		✔	
82. Aspirin?		✔	
83. Amoxicillin?		✔	
84. Codeine or other narcotics?		✔	
85. Latex?		✔	
86. Soy?		✔	
87. Eggs / yolk?		✔	
88. Sulfites?		✔	
89. Do you have any known allergies?		✔	

90. Please list any allergies other than drug allergies:

Intravaineous Dye

91. Please list any other medication or antibiotic you are allergic to:

Medication / Antibiotic Name

Is there a family history of:

❑ Cancer ❑ Diabetes ❑ Heart disease ❑ Anesthesia problems

Is this visit related to an accident? ❑ Yes ☑ No

If Yes, what type of accident? ❑ Automobile ❑ Work related ❑ Other

Date of injury _____

Insurance company handling the claim _____

Claim number _____

Name of attorney / adjustor _____

Telephone number (_____) _____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X Jonathan Kimber	X 4/30/2022	X	X
Signature of patient *(Parent or Guardian if Minor)*	**Date**	**Reviewed by**	**Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

X Jonathan Kimber	X 4/30/2022
Signature of patient *(Parent or Guardian if Minor)*	**Date**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X Jonathan Kimber	X 4/30/2022
Signature of patient: *(Parent or Guardian if Minor)*	**Date**

AUTHORIZATION

I authorize my surgeon and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x–rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone and / or mobile phone concerning my appointment.

X Jonathan Kimber	X Jonathan Kimber	X 4/30/2022
Signature of patient *(Parent or Guardian if Minor)*	**Doctor**	**Date**

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X Jonathan Kimber	X 4/30/2022
Signature of patient *(Parent or Guardian if Minor)*	**Date**

EVAN S. HALPERN, DDS
PRACTICE LIMITED TO ENDODONTICS
A Professional Corporation

909.989.0899 PHONE 909.989.1499 FAX 10801 FOOTHILL BLVD. STE 103, RANCHO CUCAMONGA, CA 91730

INFORMED CONSENT FOR ENDODONTIC THERAPY

Root canal treatment, also known as “endodontic treatment,” is a procedure that attempts to retain a tooth (or teeth) which otherwise might require extraction. It is one of the most common dental procedures performed and also one of the most successful, with a clinical success rate of over 90 percent. However, it is still a biological procedure, and success cannot be guaranteed. If you have any questions about the procedure, please feel free to ask. Dr. Halpern is always happy to answer any questions that you might have.

PLEASE DO NOT BE ALARMED BY THE FOLLOWING INFORMATION. MOST COMPLICATIONS ARE QUITE RARE.

I, the undersigned have been informed that my tooth (teeth) requires an endodontic procedure and that I fully understand the following:

1. Failure to follow this recommendation may result in: loss of the tooth (teeth), bone destruction due to an abscess, pain, or possible systemic (affecting the whole body) infection.
2. A certain percentage (5-10 percent) of root canals fail and may require re-treatment, surgery or extraction.
3. Non- surgical endodontic treatment may require more than one appointment. Failure to keep the appointment prolongs treatment, affects your comfort, and reduces the success rate.
4. Complications of root canal therapy and local anesthesia may include: swelling, pain, trismus (restricted jaw opening), infection, bleeding, sinus involvement and numbness or tingling of the lip, gum, or tongue, which rarely occurs and even more rarely permanent.
5. During treatment, complications may be discovered which may make treatment impossible, or which may require dental surgery. These complications may include: instrument broken within the root canals, perforation of the crown or root of the tooth, loss of tooth structure in gaining access to canals, blocked canals due to fillings, natural calcification, or splits/ fractures of the root.
6. About 10 percent of root canal treated teeth are lost due to periodontal disease (gum disease pyorrhea), splits or fractures of the root.
7. When making an access (opening) through an existing crown or placing a rubber dam clamp, possible damage can occur and a new crown may be necessary after endodontic therapy.
8. Successful completion of the root canal procedure does not prevent future decay or fracture.
9. To protect your tooth from decaying and fracturing, you must return to your dentist for a permanent filling or crown within a maximum of 6 weeks after the completion of the root canal therapy. The fee for the final restoration is a separate fee charged by your dentist and not included in the root canal fee. Failure to follow up for the final restoration in a timely manner may result in the failure of the root canal treatment. A fee will be charged if re-treatment or apical surgery is required due to the lack of a final restoration.
10. There are risks involved in administration of anesthetics, analgesics (pain medication) and antibiotics. I will inform the doctor of any previous side effects or allergies.

_____

PATIENT / GUARDIAN SIGNATURE DATE

_____

WITNESS SIGNATURE DATE

EVA N S. HALPERN, DDS PRACTICE LIMITED TO ENDODONTICS
A Professional Corporation

PATIENT SCREENING FOR AEROSOL TRANSMISSIBLE DISEASES (ATD)

In compliance with Cal-OSHA Title 8, Section 5199, dental facilities must pre-screen patients for aerosol transmissible diseases (ATD). Dental procedures are not performed on a patient suspected or identified as having ATD. In our office we use this Form to pre-screen a patient before any dental procedure is performed to determine whether the patient may present an ATD exposure risk.

Do you have?

A history of tuberculosis? Yes ( ) No (✔) if yes,

Explain: _____

Symptoms of tuberculosis?

Productive cough (>3 weeks): Yes ( ) No (✔) if yes,

Explain: _____

Bloody sputum Yes ( ) No (✔) if yes,

Explain: _____

Night sweats Yes ( ) No (✔)
Fatigue Yes ( ) No (✔)
Malaise Yes ( ) No (✔)
Fever Yes ( ) No (✔)
Unexplained weight loss Yes ( ) No (✔)

Flu & Other Aerosol transmissible diseases, including pertussis, measles, mumps, rubella, chicken pox, meningitis:

Do you have?

How long? Explain:

Fever? Yes ( ) No (✔)
Body aches? Yes ( ) No (✔)
Runny nose? Yes ( ) No (✔)
Headache? Yes ( ) No (✔)
Nausea? Yes ( ) No (✔)

Vomiting or diarrhea?	Yes ( )	No (✔)
Fever and respiratory symptoms?	Yes ( )	No (✔)
Severe coughing spasms?	Yes ( )	No (✔)
Painful, swollen glands?	Yes ( )	No (✔)
Skin rash, blisters?	Yes ( )	No (✔)
Stiff neck, mental changes?	Yes ( )	No (✔)

Chronic Respiratory Diseases (Not ATD and not considered infectious) do not disqualify a patient from treatment under California OSHA Title 8, Section 5199.

Do you have?

Asthma?	Yes ( )	No (✔)
Allergies?	Yes ( )	No (✔)
Chronic upper airway cough syndrome “postnasal drip”?	Yes ( )	No (✔)
Gastroesophageal reflux disease (GERD)?	Yes ( )	No (✔)
Chronic obstructive pulmonary disease (COPD)?	Yes ( )	No (✔)
Emphysema?	Yes ( )	No (✔)
Bronchitis?	Yes ( )	No (✔)
Dry cough from ACE inhibitors?	Yes ( )	No (✔)