West Coast Cosmetic Dentistry
Dr. Norma Vazquez DDS
4060 Madison St.
Riverside, CA 92504
951-352-0500

PHOTOGRAPHIC RELEASE

Photographs can be used in many ways in our office. We use them on our website as an educational tool to help patients see examples of different types of treatment. They can be used in the office in talking to patients for the same purpose. Potentially, they could be used in advertising. Almost all of the photographs are of your mouth or x-ray images. This release is for those types of images. If ever we need to use an image that will show your face so that you may be recognized by others, we will specifically ask you for permission before using that image. In consideration of my engagement as a model, upon the terms herewith stated, I hereby give to West Coast Cosmetic Dentistry, Dr. Norma Vazquez DDS, its heirs, legal representatives and assigns, those for whom (photographer) is acting, and those acting with its authority and permission:

a) The unrestricted right and permission to copyright and use, re-use, publish, and republish photographic portraits or pictures of me or in which I may be included intact or in part, composite or distorted in character or form, without restriction as to changes or transformations in conjunction with my own or a fictitious name, or reproduction hereof in color or otherwise, made through any and all media now or hereafter known for illustration, art, promotion, advertising, trade, or any other purpose whatsoever.
b) I also permit the use of any printed material in connection therewith.
c) I hereby relinquish any right that I may have to examine or approve the completed product or products or the advertising copy or printed matter that may be used in conjunction therewith or the use to which it may be applied.
d) I hereby release, discharge and agree to hold harmless (photographer), its heirs legal representatives or assigns, and all persons functioning under its permission or authority, or those for whom its is functioning, from any liability by virtue of any blurring, distortion, alteration, optical illusion, or use in composite form whether intentional or otherwise, that may occur or be produced in the taking of said picture or in any subsequent processing thereof, as well as any publication thereof, including without limitation any claims for libel or invasion of privacy.
e) I hereby affirm that I am over the age of majority and have the right to contract in my own name. I have read the above authorization, release and agreement, prior to its execution; I fully understand the contents thereof. This agreement shall be binding upon me and my heirs, legal representatives and assigns.

Name: _____

Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____

Dr. Norma Vazquez
4060 Madison St. Riverside, CA 92504
Phone: (951)352-0500 Fax: (951)352-0600

24 Hour Cancellation Agreement

It is always been our contention that your time is valuable. So we have one theory about scheduling – you deserve our undivided attention.

When we schedule a dental visit, this time is yours. It belongs to you and if by any chance you have to miss an appointment we will need a **24 hour** notice. If we do not receive notice you will be charged **$25.00** cancellation fee.

Emergencies do occur and we understand, but the cost of needlessly missed appointments is borne by us all in overhead, in time, energy, and eventually in patient fee.

Very truly your,
Norma Vazquez D.D.S and staff

Signature: _____Date: _____

Dr. Norma Vazquez

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I _____HAVE RECEIVED THE DENTAL FACT MATERIAL SHEET AND NOTICE OF PRIVACY PRACTICES FROM DR. VAZQUEZ DENTAL OFFICE AS REQUIRED BY LAW.

PATIENT/LEAGAL GUARDIAN SIGNATURE: _____

DATE: _____

Dental History

Former Dentist _____ Date of Last X-Rays _____

City, State _____ How Often Do You Floss? _____

Date of Last Dental Visit _____ How Often Do You Brush? _____

Please check all that apply:

Bad Breath ☐	Loose Teeth or Broken Fillings ☐	Sensitivity to Sweets ☐
Bleeding Gums ☐	Orthodontic Treatment ☐	Sensitivity When Biting ☐
Blisters on Lips or Mouth ☐	Pain Around Ear ☐	Frequent Headaches ☐
Finger Nail Biting ☐	Periodontal Treatment ☐	Jaw, Head or Neck Injuries ☐
Grinding Teeth ☐	Sensitivity to Cold ☐	Jaw Difficulty: Clicking and/or Pain ☐
Lip or Cheek Biting ☐	Sensitivity to Heat ☐	Tooth Pain ☐

Medical History

Physician's Name _____ Date of Last Visit _____

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had any serious illnesses or operations?	☐	☐
3. Are you currently taking any medication?	☐	☐
Please describe: _____		
4. Do you smoke?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Do you wear contact lenses?	☐	☐

7. Have you had any allergic reactions to the following:

	Yes	No
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

8. (Women Only) Are You:

Pregnant?	☐	☐
Nursing?	☐	☐
Taking birth control pills?	☐	☐

Please check all that apply:

AIDS ☐	Emphysema ☐	Pacemaker ☐
Anemia ☐	Epilepsy ☐	Psychiatric Care ☐
Arthritis, Rheumatism ☐	Fainting or Dizziness ☐	Radiation Treatment ☐
Artificial Heart Valves ☐	Glaucoma ☐	Respiratory Disease ☐
Artificial Joints ☐	Headaches ☐	Rheumatic Fever ☐
Asthma ☐	Heart Murmur ☐	Scarlet Fever ☐
Back Problems ☐	Heart Problems ☐	Shortness of Breath ☐
Bleeding abnormally, with extractions or surgery ☐	Hepatitis-Type _____ ☐	Sinus Trouble ☐
	Herpes ☐	Skin Rash ☐
Blood Disease ☐	High Blood Pressure ☐	Stroke ☐
Cancer ☐	HIV Positive ☐	Swelling of Feet/Ankles ☐
Chemical Dependency ☐	Jaundice ☐	Swollen Neck Glands ☐
Chemotherapy ☐	Jaw Pain ☐	Thyroid Problems ☐
Chronic Fatigue Syndrome ☐	Kidney Disease ☐	Tonsillitis ☐
Circulatory Problems ☐	Latex Sensitivity ☐	Tuberculosis ☐
Congenital Heart Lesions ☐	Liver Disease ☐	Tumor or growth on head/neck ☐
Cortisone Treatments ☐	Low Blood Pressure ☐	Ulcer ☐
Cough - persistent or bloody ☐	Mitral Valve Prolapse ☐	Venereal Disease ☐
Diabetes ☐	Nervous Problems ☐	

Assignment and Release

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____