REGISTRATION

(PLEASE PRINT)

JON ERIK GLENN, D.D.S.
400 Newport Center Dr., Suite 607
Newport Beach, CA 92660
Telephone: (949) 644-0071

Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ (Last Name / First Name / Middle Initial) SS/HIC/Patient ID # _____

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Partnered for _____ years ☐ Minor

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____ (Last Name / First Name / Middle Initial)

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Company(ies)) and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ Signature of Patient, Parent, Guardian or Personal Representative

_____ Date

_____ Please print name of Patient, Parent, Guardian or Personal Representative

_____ Relationship to Patient

JON ERIK GLENN, D.D.S.

400 NEWPORT CENTER DRIVE
SUITE 607
NEWPORT BEACH, CALIFORNIA 92660
(949) 644-0071

DENTAL HISTORY

PATIENT NAME:
NAME AND ADDRESS OF PREVIOUS DENTIST:
DATE OF LAST DENTAL VISIT AND WHAT TREATMENTS WERE RENDERED:
INITIAL CONCERN:

DO YOU HAVE ANY DENTAL PROBLEMS NOW? ☐ YES ☐ NO
DO YOU HAVE ANY TEETH THAT ARE SENSITIVE TO HOT OR COLD? ☐ YES ☐ NO
SWEETS? ☐ YES ☐ NO
HAVE YOU EVER HAD:
a. ORTHODONTIC TREATMENT? ☐ YES ☐ NO
b. ORAL SURGERY? ☐ YES ☐ NO
c. PERIODONTAL TREATMENT? ☐ YES ☐ NO
d. YOUR TEETH OR BITE ADJUSTED? ☐ YES ☐ NO
e. A BITE PLATE OR OTHER APPLIANCE? ☐ YES ☐ NO
HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH? ☐ YES ☐ NO
DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH? ☐ YES ☐ NO
DO YOU SUFFER FROM PAIN AND/OR SWELLING OF YOUR GUMS? ☐ YES ☐ NO
DO YOUR GUMS OFTEN BLEED WHEN YOU BRUSH YOUR TEETH? ☐ YES ☐ NO
HAVE YOUR PARENTS EXPERIENCED GUM DISEASE? ☐ YES ☐ NO
HAVE YOU EXPERIENCED:
a. CLICKING OF THE JAW? ☐ YES ☐ NO
b. PAIN (JOINT, EAR, SIDE OF FACE)? ☐ YES ☐ NO
c. DIFFICULTY IN OPENING OR CLOSING? ☐ YES ☐ NO
d. DIFFICULTY IN CHEWING? ☐ YES ☐ NO
DO YOU:
a. CLENCH OR GRIND YOUR TEETH WHILE AWAKE OR ASLEEP? ☐ YES ☐ NO
b. BITE YOUR LIPS OR CHEEKS REGULARLY? ☐ YES ☐ NO
c. HOLD FOREIGN OBJECTS WITH YOUR TEETH (SUCH AS PENCILS, PIPE, PINS, NAILS, FINGERNAILS)? ☐ YES ☐ NO
d. MOUTH BREATHE WHILE AWAKE OR ASLEEP? ☐ YES ☐ NO
DO YOU FEEL VERY NERVOUS ABOUT HAVING DENTAL TREATMENT? ☐ YES ☐ NO
HAVE YOU EVER HAD AN UPSETTING EXPERIENCE IN A DENTAL OFFICE? ☐ YES ☐ NO
DO YOU EXPECT TO EVENTUALLY LOSE YOUR TEETH? ☐ YES ☐ NO
DO YOU LIKE THE APPEARANCE OF YOUR TEETH OR SMILE? ☐ YES ☐ NO
DO YOU LIKE THE SHAPE AND COLOR OF YOUR TEETH? ☐ YES ☐ NO
DO YOU LIKE THE ALIGNMENT OF YOUR TEETH? ☐ YES ☐ NO
DO YOU HAVE SPACES BETWEEN YOUR TEETH OR CROWDED TEETH THAT BOTHER YOU? ☐ YES ☐ NO
DO YOU FEEL COMFORTABLE IN YOUR BITE, OR HOW YOUR TEETH COME TOGETHER ☐ YES ☐ NO
DO YOU HAVE ANY OLD FILLINGS OR DENTAL WORK THAT YOU DON'T LIKE LOOKING AT? ☐ YES ☐ NO
IF YOU COULD CHANGE ANYTHING ABOUT YOUR TEETH OR SMILE, WHAT WOULD IT BE?

JON ERIK GLENN, D.D.S.

400 NEWPORT CENTER DRIVE
SUITE 607
NEWPORT BEACH, CALIFORNIA 92660
949 / 644-0071

HEALTH HISTORY

Patient Name: _____ Soc. Sec. No. _____

Birth Date _____

I. CIRCLE APPROPRIATE ANSWER (leave BLANK if you do not understand question):

Yes No Is your general health good?
Yes No Has there been a change in your health within the last year?
Yes No Have you been hospitalized or had a serious illness in the last three years?
Why? _____
Yes No Are you being treated by a physician now? For what? _____
Date of last Medical Exam? _____ Date of last Dental Appt? _____
Yes No Have you had problems with prior dental treatment?
Yes No Are you in pain now?
Physician's Name _____ Address: _____ Phone: _____

II. HAVE YOU EXPERIENCED?

Yes	No	Chest pain (angina)	Yes	No	Dizziness
Yes	No	Swollen ankles	Yes	No	Ringing in ears
Yes	No	Shortness of breath	Yes	No	Headaches
Yes	No	Recent weight loss, fever, night sweats	Yes	No	Fainting spells
Yes	No	Persistent cough, coughing up blood	Yes	No	Blurred vision
Yes	No	Bleeding problems, bruising easily	Yes	No	Seizures
Yes	No	Sinus problems	Yes	No	Excessive thirst
Yes	No	Difficulty swallowing	Yes	No	Frequent urination
Yes	No	Diarrhea, constipation, blood in stools	Yes	No	Dry mouth
Yes	No	Frequent vomiting, nausea	Yes	No	Jaundice
Yes	No	Difficulty urinating, blood in urine	Yes	No	Joint pain, stiffness

III. DO YOU HAVE OR HAVE YOU HAD?

Yes	No	Heart Disease	Yes	No	HIV, Aids
Yes	No	Heart attack, heart defects	Yes	No	Tumors, cancer
Yes	No	Heart murmurs	Yes	No	Arthritis, rheumatism
Yes	No	Mitral Valve Prolapse	Yes	No	Eye diseases
Yes	No	Rheumatic fever	Yes	No	Skin diseases
Yes	No	Stroke hardening of arteries	Yes	No	Anemia
Yes	No	High blood pressure	Yes	No	VD (syphilis or gonorrhea or other S.T.D.)
Yes	No	Tuberculosis, emphysema, other lung diseases	Yes	No	Herpes
Yes	No	Hepatitis, other liver disease	Yes	No	Kidney, bladder disease
Yes	No	Stomach problems, ulcers	Yes	No	Thyroid, adrenal disease
Yes	No	ALLERGIES: to drugs, foods, medications	Yes	No	Diabetes
Yes	No	Family history of diabetes, heart problems, tumors			

IV. DO YOU HAVE OR HAVE YOU HAD?

Yes	No	Psychiatric care	Yes	No	Hospitalization
Yes	No	Radiation treatments	Yes	No	Blood transfusions
Yes	No	Chemotherapy	Yes	No	Surgeries
Yes	No	Prosthetic heart valve	Yes	No	Pacemaker
Yes	No	Artificial joint	Yes	No	Contact lenses

V. ARE YOU TAKING OR DO YOU USE?

Yes	No	Recreational drugs, (Marijuana, Cocaine, etc.)	Yes	No	Tobacco in any form
Yes	No	Drugs, medicines, (incl. Aspirin)	Yes	No	Alcohol

Please list: _____

_____

VI. WOMEN ONLY:

Yes No Are you or could you be pregnant or nursing? Yes No Taking birth control pills?

VII, ALL PATIENTS:

Yes No Do you have or have had any other diseases or medical problems NOT listed on this form?
If so, please explain: _____

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 medications. I understand that the information regarding my medical and dental history will be confidential and information will be released to other parties only after my consent is given, except when required by State or Federal laws. I have read and understand the information on the back of this sheet.

Patient Signature _____ Date _____

Doctor Signature _____ Date _____

GENERAL DENTISTRY INFORMED CONSENT

Patient _____

1. DRUGS AND MEDICATION

I understand that antibiotics, analgesics, anesthetics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, numbness, paresthesla, itching, vomiting, anaphylactic shock, or death. I authorize Dr. Glenn and any emergency medical personnel to administer any emergency medications and perform any emergency medical treatments In the event of a medical emergency.

2. FAILURE TO COMPLY WITH RECOMMENDED TREATMENTS

I understand that failure to proceed with dental treatments that have been recommended, Including x-rays, fillings, crowns, bridges, root canals, periodontal treatments, extractions and other recommended treatment may have an adverse effect on my dental health. This could lead to tooth loss, spread of infection, toothaches or more complex future treatment. I understand that referral to specialists may be needed and that I am responsible for making appointments with the specialist for the required treatment. I understand that I must comply with recommended oral hygiene procedure which includes daily flossing and regular dental exams.

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the tooth that were not discovered during examination. For example, root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

4. FILLINGS

I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common occurrence of a newly placed filling. I understand that amalgam fillings or silver fillings contain mercury and that the release of mercury from the fillings may cause mercury toxicity and health problems.

5. CROWNS, BRIDGES AND CAPS

I understand that sometimes It Is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation. It Is also my responsibility to return for permanent cementation within 30 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge or cap. I understand there will be additional charges for remakes due to my delaying permanent cementation.

6. PERIODONTAL DISEASE (TISSUE AND BONE)

I understand that I have a serious condition, causing gum and bone inflammation or lose and that it can lead to the loss of my teeth. (Following periodontal treatments such as cleanings, root planing or surgery it is common for teeth and gums to be sensitive, especially to temperature extremes, and for the teeth to look larger or have spaces between the teeth.) Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

7. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there Is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling material may extend through the tooth which does not necessarily effect the success of the treatment. I understand that endodontic files and reamers are very fine instruments and stresses vented in their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost in spite of all effort to save it.

8. REMOVAL OF TEETH

Alternatives to extractions have been explained to me (root canal therapy, crowns, and periodontal Surgery, etc.) and I authorize the dentist to extract teeth according to the treatment plan and any others necessary for reasons In paragraph #3. I understand removing teeth does not always remove all the infection, If present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesla) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.

9. DENTURES

I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty In eating are common problems. Immediate denture (placement of denture immediately after extractions) may be painful. Immediate denture may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of more than 30 days, there will be additional charges.

I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and understand that no other dentist is responsible for my dental treatment.

I hereby authorlze any of the doctors of dental auxiliaries to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undlagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees, I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation.

Signature of Patient _____ Date _____

Signature of Doctor _____ Witness _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request ill writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $ 0.15 for each page, $15.00per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a Full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our -business associates disclosed your health information for purposes, other than treatment payment, healthcare operations and certain other activities, for the last 6 years, but not before , April 14, 2003. If you request this accounting more than once in a 12-montll period, we may charge you a reasonable, cost-based fee For responding to these additional requests.

Restriction: You have tile right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions. but if we do, we will abide by our agreement (except in an emergency).

Alterative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation 110w payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why tile information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail). you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns. please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using tile contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the US Department of Health and Human Services upon request.

We support your right to the privacy of your health information, We will not retaliate in any way if you choose to file a complaint with us or with tile U.S. Department of Health and Human Services.

Contact Officer: **Elizabeth M. Glenn, Office Manager**

Telephone **949-644-0071** Fax **949-717-0685**

E-mail **jonglenndds@aol.com** glenndds.net

Address **400 Newport Center Drive #607, Newport Beach, CA 92660**

Jon E. Glenn, D.D.S., A Professional Corporation

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact: Elizabeth M. Glenn Telephone: 949-644-0071 Fax: 949-717-0685
Address: 400 Newport Center Drive, Suite 607, Newport Beach, CA, 92660
Email: jonglenndds@xxxxxxx glenndds.net.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

Jon Erik Glenn, D.D.S., A Professional Organization
400 Newport Center Drive, Suite 607
Newport Beach, California 92660
949-644-0071
jonglenndds@xxxxxxxxx.com glenndds.net

Our office confirms appointments by sending reminders via email and text messages!

Please indicate by which of the following methods you would like to communicate regarding Appointment Reminders and Confirmations, Treatment Plans, and other dental-related issues.

We promise: Your information is safe with us, and will never be shared or sold!

_____ E-mail: _____

_____ Cell Phone: _____ ☐ You have my permission to text

_____ Home: _____

_____ Work: _____

_____ Other: _____

☐ You have my permission to leave a message with whomever answers the phone.

CANCELLATION POLICY

We do require 24 hours notice for any appointments that you are unable to keep. We will always do our best to fill the time slot; however, if we're unable to do so, our No Show/late cancellation fees are as follows:

Hygiene	=	$100.00
Dr. Glenn 1 – 1.5 hour appointment	=	$125.00
Dr. Glenn 1.5 – 2+ hour appointment	=	$175.00

Signature _____ Date _____