We Would Like to Get to Know You Better!

Date_____

Full Name_____ Phone (Hm) (____)_____-_____ (Wk) (____)_____-_____

Address_____ City_____ State _____ Zip_____

Email_____ Date of birth_____ Social Security #_____-_____-_____

Drivers License #_____ Marital status_____ Spouse's name_____

Occupation_____ Employer_____ Work Hours_____

Contact in case of emergency _____ Phone (____)_____-_____

When was your last dental appointment? _____ Person responsible for your dental investment_____

How did you hear about us? _____ Why did you leave your last dentist? _____

We Want to Take Care of Your Concerns and Needs First…

What are your present dental problems? _____

Do you avoid brushing any part of your mouth? ( ) Yes ( ) No

Do your gums bleed when brushing? ( ) Yes ( ) No

Are your teeth sensitive to sweets, hot/cold, or biting pressure? ( ) Yes ( ) No

I want to know about longer lasting solutions that may cost more. ( ) Yes ( ) No

Are you dissatisfied with your teeth and their appearance? ( ) Yes ( ) No

Does dental treatment make you nervous?
( ) No ( ) Slightly ( ) Moderately ( ) Very

I think my dental health is…
( ) Excellent ( ) Good ( ) Fair ( ) Poor

If I could change my smile I would make my teeth…
( ) Whiter ( ) Straighter ( ) Close Spaces ( ) Repair Chips

Other concerns/needs of mine are _____

For Insurance Purposes…

Name of policy holder_____ Policy holder Social Security # _____ - _____ - _____

Policy holder's date of birth_____ Employer_____ Name of ins. co._____

Insurance company's Phone_____ Group #_____ Ins. Co. Address_____

Are you covered by another plan? If so please complete the following…

Name of policy holder_____ Policy holder Social Security # _____ - _____ - _____

Policy holder's date of birth_____ Employer_____ Name of ins. co._____

Insurance company's Phone_____ Group #_____ Ins. Co. Address_____

Patients name: ___ _____

Informed Consent

I understand that by signing below and initialing any of the following items that I request and authorize the procedure to be done and have read and understand the possible risks and complications of the procedure(s).

Initials_____

1) X-Rays & Examination

I understand that I will be receiving a dental examination from a state licensed dental practitioner. I understand that while X-rays are taken on my teeth that I will be exposed to a minimal amount of radiation as part of the necessary requirements to complete a thorough and comprehensive examination. I also understand that if I am pregnant radiation exposure posses a serious threat to the life and health of my unborn child. **Pregnant women are required to have medical release from their Medical Doctor prior to X-rays and Dental treatment.**

Initials_____

2) Changes in Treatment Plan

I understand that during treatment it may be necessary to change procedures or add procedures because of conditions discovered while working on the teeth that were not found during examination. I understand that there may be unforeseen changes that may occur during treatment. I understand that whenever possible, I will be informed of any treatment changes in advance. I give my permission to the Dentist to make any and/or all changes and additions as necessary.

Initials_____

3) Drugs and Medication

I understand that antibiotics, analgesics and other medications can cause allergic reactions. The reactions can cause redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock.

Initials_____

4) Removal of Teeth

Alternatives for tooth removal have been explained to me (root canal therapy, crowns, and periodontal surgery) and I authorize the Dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #2. 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 following risks involved in having teeth removed; these are pain, spread of infection, dry socket, swelling, fractured jaw, loss of feeling in my teeth, lips, tongue, and surrounding tissue that can last for an indefinite period of time. I understand I may need further treatment by a specialist, the cost of which is my responsibility. Initials_____

5) Crowns and Bridges.

I understand that I may be wearing temporary crowns, and that I must be careful to ensure that they are not removed until the permanent crowns are delivered. I understand that sometimes it is not possible to match the color of my natural teeth with artificial teeth. I realize the last opportunity to make changes in my crown, cap, or bridge will be before permanent cementation. I must return to the dentist for permanent cementation within 20 days from tooth preparation. Extended delays between the time of tooth preparation and crown cementation may allow for tooth movement, accumulation of bacteria, and/or infection of tooth structure and the surrounding tissues. This may cause the necessity to remake the crown, cap, or bridge, and even could lead to tooth loss. I understand there will be additional charges for remakes due to my delaying permanent cementation.

Initials_____

6) Root Canals/Endodontic Treatment

I understand that there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that sometimes 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 can separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment.

Initials_____

7) Periodontal Loss

I understand that I have a condition that causes gum and bone inflammation or loss and that it can lead to the loss of my 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 future adverse effect on my periodontal condition.

Initials_____

8) 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 after effect of a newly placed filling. If the sensitivity continues, I understand that a root canal may be needed, even though the tooth may not have hurt prior to the filling being done.

Initials_____

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. (Initials_____) I understand that it is my responsibility to return for delivery of the dentures. 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.

Initials_____

I understand that there has been no guarantee or assurance made by anyone in regards to my dental treatment that I have authorized. I also acknowledge that I am responsible for payment of all my dental fees regardless of any dental insurance coverage.
If you are unable to keep an appointment, please notify us at least 24 hours in advance. Failure to do so will result in a broken appointment fee of $55 per hour that was reserved for you.

Signature of Patient_____Date_____

Signature of Doctor_____Date_____

HEALTH QUESTIONAIRE

Patient Name_____

Sex_____ Age_____ Height_____ Weight_____

Date_____ Occupation_____

Marital Status_____

Directions

Please circle the appropriate answer to the questions and fill in the blanks where indicated. Answer all questions and blanks completely.

Answers to the following questions are for our records and will be considered confidential.

1. Are you in good health..... Yes No
   A. Has there been any change in your general health ..... Yes No
2. My last physical examination was on _____
3. Are you now under the care of a physician ..... Yes No
   A. If so, what is the condition being treated _____
4. The name and address of my physician is: _____ _____
5. Have you had a serious illness or operation ..... Yes No
   A. If so, what was the illness or operation:_____ _____ _____
6. Have you been hospitalized or had serious illness within the last five (5) years ..... Yes No
   A. Do you have a persistent cough or cough up blood ..... Yes No
   B. Low blood pressure ..... Yes No
   C. Venereal Disease ..... Yes No
   D. AIDS or HIV+..... Yes No
   E. Other_____ _____
7. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma ..... Yes No
   A. Do you bruise easily ..... Yes No
   B. Have you ever required a blood transfusion ..... Yes No
   If so, explain the circumstances_____ _____
8. Do you have any blood disorder such as anemia..... Yes No
9. Have you had surgery or x-ray treatment for a tumor, growth or other condition of your mouth or lips..... Yes No
10. Are you taking any drug or medication..... Yes No
    If so, what_____ _____
11. Are you taking any of the following:
    A. Antibiotics or sulfa drugs..... Yes No
    B. Anticoagulants (blood thinners)..... Yes No
    C. Medicine for high blood pressure..... Yes No
    D. Cortisone (steroids)..... Yes No
    E. Tranquilizers..... Yes No
    F. Aspirin..... Yes No
    G. Insulin, Tolbutamide (Orinase) or similar drug..... Yes No
    H. Digitalis or drugs for heart trouble..... Yes No
    I. Nitroglycerin..... Yes No
    J. Fen-Phen (now, or in the past) or any related drugs such as Ionimin, Adipex, Phentermine, Fastin, Pondimin (Fenfluramin), and Redux (dexfenfluramine)..... Yes No
    K. Oral Contraceptives..... Yes No
    If so, what are you using_____ _____
    L. Other_____ _____
12. Do you have a heart murmur/mitral valve prolapse..... Yes No
13. Do you have any implants and/or Prosthesis (i.e. knee joints, elbow pins, etc.)..... Yes No
    If so, explain_____
14. Do you drink alcoholic beverages..... Yes No
15. Do you smoke..... Yes No
    If so, how much_____
16. Do you have or have you had any of the following diseases or problems:
    A. Rheumatic fever or rheumatic heart disease..... Yes No
    B. Congenital heart lesions..... Yes No
    C. Cardiovascular disease (heart trouble, heart attack, coronary occlusion, high blood pressure, arteriosclerosis, stroke)... Yes No
       1) Do you have pain in the chest upon exertion..... Yes No
       2) Are you ever short of breath after mild exercise..... Yes No
       3) Do you get short of breath when you lie down or do you require extra pillows when you sleep..... Yes No
    D. Allergy..... Yes No
    E. Asthma or hay fever..... Yes No
    F. Hives or skin rash..... Yes No
    G. Fainting spells or seizures..... Yes No
    H. Diabetes..... Yes No
       1) Do you have to urinate (pass water) more than six (6) times a day..... Yes No
       2) Are you thirsty much of the time..... Yes No
       3) Does your mouth frequently become dry..... Yes No
    I. Hepatitis, jaundice, or liver disease..... Yes No
    J. Arthritis..... Yes No
    K. Inflammatory rheumatism (painful, swollen joints).. Yes No
    L. Stomach ulcers..... Yes No
    M. Kidney trouble..... Yes No
    N. Tuberculoses..... Yes No
17. Are you allergic or have you reacted adversely to:
    A. Local anesthetic..... Yes No
    B. Penicillin or other antibiotics..... Yes No
    C. Barbiturates, sedatives, or sleeping pills..... Yes No
    D. Sulfa Drugs..... Yes No
    E. Aspirin..... Yes No
    F. Iodine..... Yes No
    G. Latex..... Yes No
    H. Other:_____
18. Have you had any serious trouble associated with previous dental treatment..... Yes No
    If so, explain_____ _____
19. Are you pregnant or could you be..... Yes No
    If so, when are you due?_____

I certify to the best of my knowledge that the above information is correct and that if there are any changes in the above, I agree to notify my dentist before my next visit.

Patient/Guardian_____ Date_____

Doctor _____ Date_____

Updates:

Patient/Guardian_____ Doctor's Initials_____ Date_____

Patient/Guardian_____ Doctor's Initials_____ Date_____

Patient/Guardian_____ Doctor's Initials_____ Date_____

Patient Acknowledgment of
Receipt of Dental Materials Fact Sheet and
Notice of Privacy Practices

As of January 1, 2002, the Dental Board of California now requires that we distribute to our patients a copy of the Dental Materials Fact Sheet. In addition, the Heath Insurance Portability and Accountability Act (HIPAA) requires effective April 14, 2003 that patients be given a copy of our Notice of Privacy Practice.

If you would, please print and sign your name below.

I, _____, acknowledge I have received from this office

1. A copy of the Dental Materials Fact Sheet; and

2. Notice of Privacy Practices.

_____ _____
Patient Signature or Personal Representative Date

If signed by a Personal Representative of the Patient, describe the representative's authority to act for the patient. _____
_____
_____

For Office Use

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 acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

_____
_____
_____
_____