

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 poses 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 _____

CONFIDENTIAL HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?
If NO, explain: _____
2. Yes / No Has there been a change in your health within the last year?
If YES, explain: _____
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
If YES, explain: _____
4. Yes / No Are you being treated by a physician now? If YES, explain: _____
Date of last medical exam? _____ Reason for exam: _____
5. Yes / No Have you had problems with prior dental treatment?
If YES, explain: _____
Date of last dental exam: _____ Name of last treating dentist: _____
6. Yes / No Are you in pain now?
If YES, explain: _____

II. HAVE EVER YOU EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

- | | | | | | |
|----------|--------------------------------|----------|--------------------------|----------|-------------------------|
| Yes / No | Chest pain (angina) | Yes / No | Blood in stools | Yes / No | Frequent vomiting |
| Yes / No | Fainting spells | Yes / No | Diarrhea or constipation | Yes / No | Jaundice |
| Yes / No | Recent significant weight loss | Yes / No | Frequent urination | Yes / No | Dry mouth |
| Yes / No | Fever | Yes / No | Difficulty urinating | Yes / No | Excessive thirst |
| Yes / No | Night sweats | Yes / No | Ringling in ears | Yes / No | Difficulty swallowing |
| Yes / No | Persistent cough | Yes / No | Headaches | Yes / No | Swollen ankles |
| Yes / No | Coughing up blood | Yes / No | Dizziness | Yes / No | Joint pain or stiffness |
| Yes / No | Bleeding problems | Yes / No | Blurred vision | Yes / No | Shortness of breath |
| Yes / No | Blood in urine | Yes / No | Bruise easily | Yes / No | Sinus problems |
- Other: _____

III. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

- | | | | | | |
|----------|---------------------------------|----------|---------------------------------|----------|----------------------------|
| Yes / No | Heart disease | Yes / No | AIDS/HIV | Yes / No | Psychiatric care |
| Yes / No | Family history of heart disease | Yes / No | Surgeries | Yes / No | Osteoporosis |
| Yes / No | Heart attack | Yes / No | Hospitalization | Yes / No | Thyroid disease |
| Yes / No | Artificial joint | Yes / No | Diabetes | Yes / No | Asthma |
| Yes / No | Stomach problems or ulcers | Yes / No | Family history of diabetes | Yes / No | Hepatitis |
| Yes / No | Heart defects | Yes / No | Tumors or cancer | Yes / No | Sexual transmitted disease |
| Yes / No | Heart murmurs | Yes / No | Chemotherapy | Yes / No | Herpes |
| Yes / No | Rheumatic fever | Yes / No | Radiation | Yes / No | Canker or cold sores |
| Yes / No | Skin disease | Yes / No | Arthritis, rheumatism | Yes / No | Anemia |
| Yes / No | Hardening of arteries | Yes / No | Emphysema or other lung disease | Yes / No | Liver disease |
| Yes / No | High blood pressure | Yes / No | Kidney or bladder disease | Yes / No | Eye disease |
| Yes / No | Seizures | Yes / No | Stroke | Yes / No | Transplants |
| Yes / No | Cosmetic surgery | Yes / No | Eating disorders | Yes / No | Tuberculosis |
- Other: _____

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please circle Yes or No for each)

- | | | | | | |
|----------|---------------------------------|----------|---------------------------|----------|----------------------------|
| Yes / No | Aspirin | Yes / No | Valium or other sedatives | Yes / No | Codeine or other narcotics |
| Yes / No | Penicillin or other antibiotics | Yes / No | Latex | Yes / No | Food |
| Yes / No | Nitrous oxide | Yes / No | Local anesthetic | Yes / No | Metal |
- Others: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?
 (Please circle Yes or No for each)

- | | | | | | |
|----------|----------------------------|----------|--------------------------|----------|-------------|
| Yes / No | Recreational drugs | Yes / No | Tobacco in any form | Yes / No | Antibiotics |
| Yes / No | Over-the-counter medicines | Yes / No | Alcohol | Yes / No | Supplements |
| Yes / No | Weight loss medications | Yes / No | Bisphosphonate (Fosamax) | Yes / No | Aspirin |
| Yes / No | Anti-Depressants | Yes / No | Herbal supplements | | |

Please list all prescription medications: _____

VI. WOMEN ONLY (Please circle Yes or No for each)

- Yes / No Are you or could you be pregnant? If YES, what month? _____
- Yes / No Are you nursing? _____
- Yes / No Are you taking birth control pills? _____

VII. ALL PATIENTS (Please circle Yes or No for each)

- Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
 If YES, please explain: _____
- Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: _____
- Yes / No Have you ever taken Fen-Phen? If YES, when: _____
- Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____
 Physician's Name: _____ Phone Number: _____

Whom would you like us to contact in case of an emergency?

Name: _____ **Relationship:** _____ **Phone Number:** _____

I certify that I have read and understand this form. 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 medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian) Date Signature of Dentist Date

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**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 Health 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)

