Date: _____

GETTING TO KNOW YOU AS OUR PATIENT

Patient Name		Social Security Number	Home Phone ( )
Home Address		City, State, Zip	Cell Phone
Email Address			Work Phone
Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Separated	☐ **MALE** ☐ **FEMALE**	Birthdate / /	Drivers License and State
Primary Insurance Company _____		Group _____	Subscriber _____
Secondary Insurance Company _____		Group _____	Subscriber _____

Responsible Party			
Name		Social Security Number	Home Phone ( )
Home Address		City, State, Zip	Birthdate / /
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated		Relationship to Patient	Drivers License and State
Responsible Person's Employer		Occupation	Work Phone ( )
Business Address		City	State Zip

Spouse's Name	Social Security Number	Birthdate / /
Spouse's Employer	Spouse's Occupation	Spouse's Work Phone ( )
Spouse's Business Address	City	State Zip

How did you hear about our Office?

(check only one)

Who selected this Office? ☐ Self ☐ Spouse ☐ Parent ☐ Employer

Where did you find the Phone Number to this Office? _____

☐ Referred by a friend ☐ Yellow Pages ☐ Relative ☐ Insurance Plan ☐ Welcome Wagon

☐ Other_____ ☐ TV/Radio Ad ☐ Newspaper AD ☐ Direct Marketing ☐ Sign by Building

If you were referred, whom may we thank for referring you? _____

CONSENT

*I will answer all health questions to the best of my knowledge. _____ *(Initial)*

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgement of the doctor may dictate in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

_____ _____ _____

**Signature* *Date* *Relationship to Patient*

Terms and Conditions

This office depends upon reimbursement from the patient for the costs incurred in their care. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time services are performed.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize release of any information needed and also authorized my insurance company to pay directly to This Office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceeding shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

Signed _____ Date _____

There may be a charge for any missing appointments or appointments not cancelled 24 hours before the appointment time.

PATIENTS DENTAL HEALTH

Why have you come to see us today? (e.g.: pain, checkup, etc.) _____

Previous Dentist _____ Last Visit _____ **Date of last cleaning** _____

Reasons for changing dentists: _____

What problems have you had with past dental treatment? _____

Are you nervous about seeing a dentist? ☐ Yes! ☐ No If yes please, tell us why: _____

How often do you brush? _____ Do you floss? ☐ Yes ☐ No **How often?** _____

(please circle each)

Y N I clench or grind my teeth during the day or while sleeping.
Y N My gums bleed while brushing or flossing.
Y N I would like to improve my smile.
Y N I prefer tooth-colored fillings.
Y N I avoid brushing part of my mouth due to pain.
Y N My gums feel tender or swollen.
Y N I have problems eating.
Y N I have had orthodontics.
Y N I have had a facial or jaw injury.
Y N I want my teeth straighter.
Y N I want my teeth whiter.

What are your dental priorities? _____
(e.g.: appearance, dental health, financial considerations, etc.)

PATIENTS MEDICAL HISTORY

I consider my health to be *(check one)*: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have or have you had any of the following? *Please circle Y for yes or N for no.*

1 Y N Heart Disease
2. Y N Heart Murmur/Mitral Valve Prolapse
3. Y N Stroke
4. Y N Congenital Heart Lesions
5. Y N Rheumatic Fever
6. Y N Pacemaker
7 Y N Stent
8. Y N Abnormal Blood Pressure
9. Y N Anemia
10. Y N Prolonged Bleeding Disorder
11 Y N Tuberculosis or Lung Disease
12. Y N Asthma
13. Y N Hay Fever
14. Y N Sinus Trouble
15. Y N Epilepsy/Seizures
16. Y N Ulcers
17 Y N Implants/Artificial Joints: Hip-Knee _____ Other _____
18. Y N I smoke or use chewing tobacco. If yes, how much per day?_____ How many years? _____
19. Y N I have consumed alcohol within the last 24 hours.
20. Y N I usually take an antibiotic prior to dental treatment.
21 Y N Have you ever taken Fen-Phen or Redux?
22 Y N Do you take or have you ever taken Bisphosphonates (Fosamax, Boniva, Actonel, Aredia, Zometa, etc.) for Osteoporosis or any other condition?
23 Y N I have had major surgery. Year _____ Type of operation _____ Year _____ Type of operation _____
24. Y N Do you have any other medical problem or medical history NOT listed on this form? _____

25. Y N Liver Disease
26. Y N Jaundice
27 Y N Hepatitis Type _____
28. Y N Diabetes
29. Y N Excessive Urination and/or Thirst
30. Y N Infectious Mononucleosis ("Mono")
31 Y N Herpes
32. Y N Arthritis
33. Y N Sexually Transmitted/Venereal Diseases
34. Y N Kidney Disease
35. Y N Tumor or Malignancy
36. Y N Cancer/Chemotherapy
37 Y N Radiation/Therapy
38. Y N History of Drug Addiction

39. Y N HIV
40. Y N AIDS
41. Y N Immune Suppressed Disorder
42. Y N Hearing Loss
43. Y N Fainting Spells
44. Y N Glaucoma
45. Y N History of Emotional or Nervous Disorders

WOMEN:

46. Y N Are you taking birth control medication?
47 Y N Are you or could you be pregnant or nursing?

Doctor Notes Only:

Are you allergic to any of the following?
Please circle Y for yes or N for no

48. Y N Aspirin
49 Y N Ibuprofen
50. Y N Sulfa Drugs/Sulfites/Sulfides
51 Y N Penicillin
52 Y N Codeine
53. Y N Latex, Metals, Plastics
54 Y N Local Anesthetics (i.e., Novocain, Lidocaine
55 Y N Other Medications Which ones?_____

Please list all medications you are currently taking:

Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____
Physician's Name _____ Phone _____
Address _____ Fax _____

In the event of an emergency please contact:

Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____

Initial medical/dental health reviewed by:

X _____ / ____ / ____
Doctor's Signature *Date*

Periodic medical/dental health reviewed by:

X _____ / ____ / ____
Doctor's Signature *Date*

X _____ / ____ / ____
Doctor's Signature *Date*

X _____ / ____ / ____
Doctor's Signature *Date*

X _____ / ____ / ____
Patient's Signature *Date*

X _____ / ____ / ____
Patient's Signature *Date*

X _____ / ____ / ____
Patient's Signature *Date*

X _____ / ____ / ____
If Patient is a minor: must have Guardian's Signature *Date*

San Gabriel Valley Family Dental Group
6503 North Rosemead Blvd
San Gabriel, CA 91775
626-2862156

NO SHOW POLICY

A "no show" is someone who misses an appointment without cancelling it 24 hours in advance. No-shows inconvenience those individuals who need access to dental care in a timely manner.

An administrative fee of $40.00 will be billed to the patient's account for a "no show" regular office visit.
The patient will be sent a bill because they failed to show up foe an appointment an did not cancel the appointment 24 hours in advance.

Thank you in advance for keeping your appointments!

NOTE BY:

Patient's Name	Signature	Date

Acknowledgement of Receipt of Notice of Privacy Practices

SAN GABRIEL VALLEY FAMILY DENTAL GROUP

** You May Refuse to Sign This Acknowledgement**

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

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 obtain because:

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

_____

_____

_____

INFORMED CONSENT

Name _____ Chart Number _____

1. **DRUGS AND MEDICATIONS**
   I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).
2. **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 teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary, after having been informed and in agreement with the changes.
3. **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.
4. **DENTURES - COMPLETE OR PARTIAL**
   I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me including looseness, soreness, and possible breakage, and relining due to tissue change.
5. **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 metal objects are cemented to the tooth or extended through the root which does not necessarily affect the success of the treatment
6. **PERIODONTAL TREATMENT**
   I understand that although Periodontal treatment, including scaling and gum surgery, has a high degree of success it cannot be guaranteed. Occasionally, teeth may require extraction.

MATERIALS

I acknowledge I have received from San Gabriel Valley Family Dental a copy of the Dental Materials Fact Sheet dated October 2001.

I hereby request and authorize the Dentist and their Staff to perform dental work upon me for the purpose of attempting to improve my appearance, function and the health of my mouth, teeth, bone and tissue, as explained above.

I also authorize the operating Dentist and Assistants to perform any other procedure which they may deem necessary or desirable in attempting to improve the condition stated on the diagnostic treatment form, or treat unhealthy or unforeseen conditions that may be encountered during the operation.

I know that the practice of Dentistry and surgery 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 treatment which I have requested and authorized.

I also understand that it is my responsibility inform the Dentist if I am having any problems during the following treatment so as to allow him to help minimize any problems.

I understand that complications, such as infection, hemorrhage and/or bleeding, scarring, contraction, possible deformities, prolonged healing time over the estimate reaction to any drugs before, during and after surgery, numbness or itching of the tongue, lip teeth, issues (Parasthesia), fractured jaw etc., can occur

I CERTIFY THAT I HAVE BEEN AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT AND THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE. ANYTHING I DID NOT UNDERSTAND HAS BEEN EXPLAINED TO ME.

Signature _____ Relationship _____ Date _____

Doctor _____ Witness _____ Date _____

SAN GABRIEL VALLEY FAMILY DENTAL GROUP

TMJ HEALTH QUESTIONNAIRE

NAME _____ **Date** _____

PAIN SYMPTOMS

Do you get headaches?	Y	N
Do you get migraine headaches?	Y	N
Do you frequently have neck aches or stiff neck muscles?	Y	N
Have you ever had chronic shoulder or back pain?	Y	N
Do you have trouble sleeping soundly?	Y	N
Are your jaws tired when you awaken?	Y	N
Are your teeth sore when you awaken	Y	N
Are your wisdom teeth extracted?	Y	N

What medication (s) if any, are you taking?

_____

_____

Do you get headaches in right or left temple areas?	Y	N
Do you get headaches in the front or back of your head?	Y	N
Do you clench your teeth during the day?	Y	N
Do you clench your teeth during the night?	Y	N
Do you grind your teeth when asleep?	Y	N

When are your symptoms worse?

_____

Does anything make you feel better?

_____

_____

How often do you take medication for relief of pain?

a) Never b) Weekly to Monthly c) Weekly d) Daily

TRAUMA OR ACCIDENTS

Have you ever had a severe blow to the head or jaw?	Y	N
Any whiplash neck injuries?	Y	N

Have you ever been involved in any serious accidents such as a car accident? Y N

Details _____

_____

JAW JOINT SYMPTOMS

Does your jaw feel tired after a big meal?	Y	N
Are there any foods you avoid eating?	Y	N
Do you ever get dizzy?	Y	N
Do you ever feel faint?	Y	N
Do you ever feel nauseated (sick)?	Y	N
Is there a family history of jaw joint (TMJ) problems or headaches?	Y	N

Do you feel or hear a 'clicking' 'popping' or 'cracking' noise from either jaw joint?	Y	N
Has your jaw ever locked when you were unable to open or close?	Y	N
Do you have difficulty opening wide or yawning?	Y	N
Have you ever had pain in either jaw joint?	Y	N
Does your jaw ache when you open wide?	Y	N

EAR AND EYE SYMPTOMS

Do you have any pain in your ears?	Y	N
Do you suffer from any loss of hearing?	Y	N
Do you have itchiness or stuffiness in either ear?	Y	N
Do you hear ringing, buzzing or hissing sounds in either ear?	Y	N

Do you wear glasses or contacts?	Y	N
Are there times when your eyesight blurs?	Y	N
Do you get pain in, around or behind either eye?	Y	N

BREATHING

Do you have allergies?	Y	N
Do you have sinus problems?	Y	N
Do you have snore at night?	Y	N

Is your nose stuffed when you don't have cold?	Y	N
Have you been diagnosed with Sleep Apnea?	Y	N
Have you had a sleep study done at a Sleep Clinic (hospital)?	Y	N

SIGNATURE _____