






Dental Wonderland

General Dentistry 
 Cosmetic Dentistry 
 Endodontics 
 Oral Surgery 
 Orthodontics 
 Periodontics

DENTAL HISTORY

How may we help you today? _____

Your current dental health is: Good Fair Poor

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

Have you ever had gum treatment? Yes No

Do you now or have you had any pain/discomfort jaw joint? (TMJ) Yes No

Are you under any stress (i.e. new job, moving, relationships) Yes No

Do you like your smile? Yes No

Are you happy with the color of your teeth? Yes No

Do your gums bleed? Yes No

How many times do you: floss/week? _____ brush/day? _____

Are you sensitive to heat, cold or anything else? Yes No

Have you lost any permanent teeth? Yes No

Do you grind or clench your teeth? Yes No

Have you ever had a serious/difficult problem with any previous dental work? Yes No

Have you ever had any unfavorable dental experiences? Yes No

When was your last visit: Cleaning? _____ Dental Visit? _____






Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit? _____

Here at La Puente Village Dentistry we offer a wide variety of services to enhance and keep your smile beautiful. Please check any services below that you would like our friendly staff to discuss with you during your visit.

- | | | |
|---------------------------------------------------------|-----------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Zoom! One-hour Teeth Whitening | <input type="checkbox"/> Veneers/Lumineers | <input type="checkbox"/> Bonding |
| <input type="checkbox"/> Take-home Bleaching Trays | <input type="checkbox"/> Smile Makeover | <input type="checkbox"/> Implant Crowns |
| <input type="checkbox"/> Partial/Dentures | <input type="checkbox"/> Crowns & Bridge | <input type="checkbox"/> Replace Silver Fillings |
| <input type="checkbox"/> Nightguard/Sportsguard | <input type="checkbox"/> Sealants | <input type="checkbox"/> Straighter Teeth |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Fixing Chipped Teeth | |

Dental Wonderland

General Dentistry  Cosmetic Dentistry  Endodontics  Oral Surgery  Orthodontics  Periodontics

PATIENT INFORMATION (PLEASE FILL OUT COMPLETELY)

First Name: _____	Last Name: _____	Middle Initial: _____
Preferred Name: _____	Patient Is: <input type="checkbox"/> Policy Holder	<input type="checkbox"/> Responsible Party <input type="checkbox"/> Child
Address: _____	City, State and Zip: _____	
Home Phone: _____	Work Phone: _____	Mobile: _____
Email Address: _____		
Birth Date: _____	Soc. Sec: _____	Drivers Lic: _____
Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Self Employed <input type="checkbox"/> Other	Gender: _____	
Marital Status: <input type="checkbox"/> Child <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Other		
Student Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time		
School /Employer Name: _____	Preferred Pharmacy/Phone: _____	

PARENT/GUARDIAN INFORMATION (For minors 17yrs & younger)

First Name: _____	Last Name: _____	Middle Initial: _____
Address: _____	City, State and Zip: _____	
Home Phone: _____	Work Phone: _____	Mobile: _____
Email Address: _____	Relationship to Patient: _____	
Birth Date: _____	Soc. Sec: _____	Drivers Lic: _____
Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Self Employed <input type="checkbox"/> Other	Gender: _____	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Other		

PRIMARY INSURANCE (IF APPLICABLE, PLEASE FILL OUT COMPLETELY)

Name of Insured: _____	Relation to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Insured ID/SSN: _____	Insured DOB: _____
Employer: _____	Ins. Company: _____
Address: _____	Address: _____
City, State and Zip: _____	City, State and Zip: _____
Phone: _____	Phone: _____

SECONDARY INSURANCE (IF APPLICABLE, PLEASE FILL OUT COMPLETELY)

Name of Insured: _____	Relation to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Insured ID/SSN: _____	Insured DOB: _____
Employer: _____	Ins. Company: _____
Address: _____	Address: _____
City, State and Zip: _____	City, State and Zip: _____
Phone: _____	Phone: _____

REFERRAL SOURCE (WHO CAN WE THANK?)

--

SIGNATURE OF PATIENT, PARENT or GUARDIAN: _____ DATE: _____

PATIENT HEALTH HISTORY

Patient Name: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions completely.

- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Are you on a special diet? Yes No _____
- Do you use tobacco? Yes No
- Do you use controlled substances? Yes No

WOMEN, ARE YOU...

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

ARE YOU ALLERGIC TO THE FOLLOWING...

Aspirin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Acrylic	<input type="checkbox"/> Yes <input type="checkbox"/> No	Metal	<input type="checkbox"/> Yes <input type="checkbox"/> No	Local Anesthetics	<input type="checkbox"/> Yes <input type="checkbox"/> No
Penicillin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Codeine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Latex	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Other, please explain: _____

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING...

AIDS/HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimer's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anaphylaxis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B or C	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Easily Winded	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Press.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hives or Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joint	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular Heartbeat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spina Bifida	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting Spells/Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach/Intestinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Limbs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breathing Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Genital Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in Jaw Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors or Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pains	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack/Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parathyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cold Sores/Fever Blisters	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Pace Maker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Yellow Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No
Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Trouble/Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Weight Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

IN CASE OF EMERGENCY CONTACT...

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

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT or GUARDIAN: _____ Date: _____

MEDICAL HEALTH REVIEWED BY (DOCTOR): _____ Date: _____

GENERAL DENTISTRY INFORMED CONSENT

Patient: _____

DOB: _____

PLEASE ONLY INITIAL #1, #2 & #3. DO NOT INITIAL ANY OTHERS WITHOUT BEING ADVISED BY OFFICE STAFF.

1. WORK TO BE DONE

Exam/X-rays Fillings Crown/Bridge

I understand that I am having the following work done: Extractions Root Canals Dentures Initials _____

2. DRUGS AND MEDICATION

I understand that antibiotics, analgesics and other medications can cause allergies reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock. Initials _____

3. CHANGES IN THE 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 the 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. Initials _____

4. REMOVAL OF TEETH

Alternatives to 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 other necessary 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 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 (Parasthesia) that can last for an indefinite period of time or fractured jaw. I understand that I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility. Initials _____

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 a 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 (shape, fit, size and color) will be before cementations. It is also my responsibility to return for permanent cementation within 20 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 the remakes due to my delaying. Initials _____

6. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, and that complication can occur from the treatment and that occasionally root canal filling material may extend through the tooth which does not necessarily affect 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. Initials _____

7. PERIODONTAL LOSS (TISSUE AND BONE)

I understand that I have a serious condition, causing 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 any dental procedures may have future adverse effect on my periodontal condition. Initials _____

8. FILLINGS

I understand that care must be exercised in chewing with 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 placed. 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 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 deliver of the dentures. I understand that failure to keep my appointments 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 dentistry is not an exact science and that therefore, reputable practioners 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 authorized. I understand that regardless of any dental insurance covered I may have, I am responsible for payment of dental fees. I agree to pay any attorney fees, collection fees, or court costs that may be incurred to satisfy this obligation.

SIGNATURE OF PATIENT, PARENT or GUARDIAN: _____ DATE: _____

SIGNATURE OF TREATING DENTIST/DOCTOR: _____ DATE: _____

PATIENT ACKNOWLEDGEMENT 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) require that patients be given a copy of our Notice of Privacy Practice.

If you would, please print and sign your name below acknowledging you have received these forms from this office.

1. A copy of the Dental Materials Fact Sheet; and
2. Notice of Privacy Practices.

PRINT NAME OF PATIENT/PARENT/GUARDIAN

X _____
SIGNATURE OF PATIENT/PARENT/GUARDIAN

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)

© 2002 American Dental Association
All Rights Reserved

Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).