

PATIENT INFORMATION

PATIENT

Name _____
Last First

Address _____ Apt. # _____

City _____ Zip _____

How long at this address? _____

Phone () _____

Cell/Pager () _____

E-mail _____

Social Security # _____

DL# _____

Age _____ Birthdate _____

Primary Language _____

Ethnicity _____

GETTING TO KNOW YOU

Do you have family members who may need dental care?
 If so, please list name & relationship (son, daughter, husband)

1: _____ 2: _____

3: _____ 4: _____

How did you hear about our office? (Circle one)

Family-Friend (400)	Insurance Plan (460)
ConfiDent® (440)	Television (020)
Newspaper (470)	Radio (030)
Billboard (050)	Yellow Pages (120)
Flyer-Coupon (490)	Direct Mail Postcard (480)
Office Sign (420)	Internet-Website (190)
Office Transfer (430)	

I want information in Spanish: YES _____ NO _____

EMPLOYMENT

Occupation _____

Employer _____

How Long? _____

Business Address _____

City _____ Zip _____

Business Phone () _____ Ext. # _____

Verified By _____ Date _____

(Office use only)

REFERENCES

Name _____
Last First

Phone () _____

Name _____

Phone () _____

Spouse's Name _____
Last First

Spouse's Work Phone () _____

PERSON TO CONTACT FOR EMERGENCY:

Last First

Phone () _____

Physician _____ Phone () _____

RESPONSIBLE PARTY (If same as above, please skip)

Name _____
Last First

Address _____ Apt. # _____

City _____ Zip _____

How long at this address? _____

Phone () _____

Social Security # _____ DL# _____

Relationship to Patient _____

Age _____ Birthdate _____

INSURANCE / DENTAL PLAN

Primary: Insurance PPO HMO (Circle one)

Plan Name _____

Address _____

City, Zip _____

Insurance / Plan Phone # _____

Employer _____

Union/Local _____ Group # _____ Plan# _____

Insured's Name _____

Insured's Soc. Sec. # _____ Birthdate _____

INSURANCE / DENTAL PLAN

Secondary: Insurance PPO HMO (Circle one)

Plan Name _____

Address _____

City, Zip _____

Insurance / Plan Phone # _____

Employer _____

Union/Local _____ Group # _____ Plan# _____

Insured's Name _____

Insured's Soc. Sec. # _____ Birthdate _____

INSURANCE / MEDICAL PLAN

Primary: Insurance PPO HMO (Circle one)

Plan Name _____

Address _____

City, State, Zip _____

Insurance / Plan Phone # _____

Employer _____

Union/Local _____ Group # _____ Plan# _____

Insured's Name _____

Insured's Soc. Sec. # _____ Birthdate _____

1. I certify that the information provided is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid by my insurance for whatever reason.
2. By signing below, I authorize that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies.
3. I authorize payment directly to the dentist of any group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims.
4. I understand that this dental practice is owned and operated by an independent dentist. I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist or corporate entity is responsible for my dental treatment.

 Signature of Responsible Party or Patient
 (Parent if Patient is a Minor)

 Date

GENERAL HEALTH INFORMATION

DATE: _____

PATIENT NAME: _____ BIRTH DATE: _____ AGE: _____
LAST FIRST

DENTAL HISTORY

1. Reason for Visit / Main Concern? Check-Up Cleaning Toothache Other _____
2. Are there other conditions of which we should be aware? YES NO If yes, please specify: _____
3. When did you last visit a dentist? _____
4. What treatment was performed? _____
5. Was the treatment completed? _____
6. When were dental x-rays taken? _____
7. Did you have a cleaning? YES NO
8. Have you had gum (periodontal) treatment? YES NO
9. Have you ever had prolonged bleeding after an extraction? YES NO If yes, please specify: _____
10. Have you had any problems with past dental treatment? YES NO If yes, please specify: _____
11. Do you grind your teeth, clench your jaws, or have symptoms near your ears such as clicking, popping, pain or locking open? YES NO If yes, please specify: _____
12. Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction) sometimes called TMJ? YES NO If yes, please specify: _____
13. Do your gums bleed easily? YES NO
14. Do you feel you have bad breath? YES NO
15. Are your teeth sensitive to hot or cold? YES NO
16. Would you like your teeth whiter? YES NO
17. Are you happy with your smile? YES NO If no, please explain: _____

MEDICAL HISTORY

1. Are you under a Doctor's care at this time? YES NO If yes, please specify: _____ Dr. Name: _____
Dr. Phone: () _____
2. Are you allergic to penicillin, codeine, local anesthetics, tranquilizers or any other drugs or medicine? _____
3. Are you taking any medications at this time, including birth control? YES NO If yes, please specify: _____
4. (Women) Are you pregnant now? YES NO If yes, how many months? _____ Are you nursing? YES NO
5. Are there any other health problems of which we should be advised? Please specify: _____
6. Do you have, or have you had, any of the following?

Please check "YES" or "NO"	Doctor Comments	Please check "YES" or "NO"	Doctor Comments
ARTIFICIAL HEART VALVE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	HEPATITIS YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
AIDS/HIV+ YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	HIGH BL. PRESSURE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
ANEMIA YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	JAUNDICE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
ANGINA YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	JOINT REPLACEMENT YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
ARTHRITIS YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	KIDNEY DISEASE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
ASTHMA YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	LATEX ALLERGY YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
BISPHOSPHONATE THERAPY YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	LIVER PROBLEMS YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
BLEEDING PROBLEMS YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	LOW BL. PRESSURE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
CANCER YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	LUNG DISEASE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
CHEMO/RAD THERAPY YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	PACEMAKER YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
COSMETIC SURGERY YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	PSYCHIATRIC CARE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
DIABETES YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	RHEUMATIC FEVER YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
DIZZY SPELLS YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	SINUS TROUBLE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
DRUG ADDICTION YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	SLEEP APNEA YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
EMPHYSEMA YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	TOBACCO YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
EPILEPSY YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	STROKE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
FAINTING YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	THYROID PROBLEMS YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
GLAUCOMA YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	TMD OR TMJ YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
HEART ATTACK/SURGERY YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	TUBERCULOSIS YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
HEART MURMUR/PROBLEMS YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	VENEREAL DISEASE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____

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. I further certify that I consent to taking x-rays and an oral examination.

Patient's signature _____ Date _____
(Parent if Patient is a Minor) Doctor Signature _____

MEDICAL UPDATE:

1. Patient's signature _____ Doctor's Signature _____ Date _____
2. Patient's signature _____ Doctor's Signature _____ Date _____
3. Patient's signature _____ Doctor's Signature _____ Date _____

Informed Consent General Dentistry

All patients complete 1 thru 4 below, and 5 thru 13 as needed.

1. EXAMINATIONS AND X-RAYS

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. I understand I am to have work done as detailed in the attached treatment plan.

(Initials _____)

2. DRUGS, MEDICATION AND SEDATION

I have been informed and 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). I have informed the Dentist of any known allergies. They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness or oral contraceptives (birth control pills). I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am current taking.

The written informed consent, in the case of a minor, shall include, but not be limited to, the following information: The administration and monitoring of general anesthesia may vary depending on the type of procedure, the type of practitioner, the age and health of the patient, and the setting in which anesthesia is provided. Risks may vary with each specific situation. You are encouraged to explore all the options available for your child's anesthesia for his or her dental treatment, and consult with your dentist or pediatrician as needed.

(Initials _____)

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 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.

(Initials _____)

4. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)

I understand that popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility.

(Initials _____)

5. DENTAL PROPHYLAXIS (CLEANING)

I understand the treatment is preventative in nature, intended for patients with healthy gums, and is limited to the removal of plaque and calculus from the tooth structures in the absence of periodontal (gum) disease.

(Initials _____)

6. FILLINGS

I understand that a more extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure found during preparation. This may lead to other measures necessary to restore the tooth to normal function. This may include root canal, crown, or both. I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I understand that sensitivity is a common after effect of a newly placed filling.

(Initials _____)

7. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crown, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth _____ 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, exposed sinuses, 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 bleeding could last for several hours. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contacted. I understand that I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

(Initials _____)

8. CROWNS, BRIDGES, VENEERS AND BONDING

a. 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 that the final opportunity to make changes in my new crown, bridge, or veneer (including shape, fit, size and color) will be before cementation. It has been explained to me that, in a very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures. It is also my responsibility to return for permanent cementation within 20 days after tooth preparation. Excessive delays may allow for decay, tooth movement, gum disease, and/or bite problems. This may necessitate a remake of the crown, bridge, or veneer. I understand there will be additional charges for remakes or other treatment due to my delaying permanent cementation.

(Initials _____)

b. I am electing to use noble, high noble or ceramic instead of base metal in my crown and bridge restorations.

(Initials _____)

c. I am electing to do a fixed bridge or implant replacement of missing teeth instead of a removable appliance. I understand that this fixed bridge or implant and crown may not be a covered benefit under my insurance policy.

(Initials _____)

9. DENTURES – COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. Immediate dentures (placement of dentures immediately after extractions) may be uncomfortable at first. Immediate dentures may require several adjustments and relines. A permanent reline or a second set of dentures will be necessary later. This is not included in the initial denture fee. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. I understand that it is my responsibility to return for delivery of dentures. I understand that failure to keep delivery appointments may result in poorly fitted dentures. If a remake is required due to my delay of more than 30 days, there will be additional charges.

(Initials _____)

10. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, that complications can occur from the treatment, and that occasionally, canal material may extend through the root tip which does not necessarily affect the success of the treatment. The tooth may be sensitive during treatment and even remain tender for a time after treatment. Hard to detect root fracture is one of the main reasons root canals fail. Since teeth with root canals are more brittle than other teeth, a crown is necessary to strengthen and preserve the tooth. I understand that endodontic files and reamers are very fine instruments and stresses 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 efforts to save it.

(Initials _____)

11. PERIODONTAL TREATMENT

I understand that I have a serious condition causing gum inflammation and/or bone loss, and that it can lead to the loss of my teeth and/or negative systemic conditions (including uncontrolled diabetes, heart disease, and pre-term labor, etc.). Alternative treatment plans have been explained to me, including non-surgical therapy, antibiotic/antimicrobial treatment, gum surgery, and/or extractions. I understand the success of any treatment depends in part on my efforts to brush and floss daily, receive regular therapeutic cleanings as directed, follow a healthy diet, avoid tobacco products and follow other recommendations. I understand bleeding could last for several hours. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contacted. I understand that periodontal disease may have a future adverse effect on the long-term success of dental restoration work.

(Initials _____)

12. IMPLANTS

I understand that no dentistry is permanent and that ideal implant placement may not be possible based on anatomic limitations. I have been informed that there is always the possibility of failure resulting from the tissues of the body not physiologically accepting these artificial devices, and infections may occur post operatively which may necessitate removal of the affected implant(s). I realize there is the slight possibility of injury to the nerves of the face and tissues of the oral cavity, and this numbness may be of a temporary or, rarely, permanent in nature. I understand that it is absolutely necessary with implant therapy to have regular periodic examinations and cleanings. I agree to assume the responsibility to make appointments and report as instructed by the treating dentist.

(Initials _____)

13. BLEACHING

Bleaching is a procedure done either in office (approximately 1 hour) or with take-home trays (several treatments over 2-4 weeks). The degree of whitening varies with the individual. The average patient achieves considerable change (1-3 shades on the dental shade guide). Coffee, tea and tobacco will stain teeth after treatment and are to be avoided for at least 24 hours after treatment. I understand I may experience sensitivity of the teeth and/or gum inflammation, which may subside when treatment is discontinued. The Dentist may prescribe fluoride treatments to aid with sensitivity. Carbamide peroxide and other peroxide solutions used in teeth bleaching are approved by the FDA as mouth antiseptics. Their use as bleaching agents has unknown risks. Acceptance of treatment means acceptance of risk. Pregnant women are advised to consult with their physician before starting treatment.

(Initials _____)

14. NITROUS OXIDE

I elect to have nitrous oxide in conjunction with my dental treatment. I have been informed and understand the possible side effects that may occur. These include, but are not limited to, nausea, vomiting, dizziness and headache. I understand that nitrous oxide use is not indicated if I am pregnant.

(Initials _____)

15. DENTAL BENEFITS

I understand that my insurance may provide only the minimum standard of care. I understand that submitting insurance and receiving a benefit is my responsibility. I elect to follow the Dentist's recommendation of optimal dental treatment.

(Initials _____)

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 I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist or corporate entity, other than the treating Dentist, is responsible for my dental treatment. I acknowledge the receipt of and understand post-operative instructions and have been given an appointment date to return.

Patient Signature _____ Date: _____

Doctor: _____ Date: _____

CALIFORNIA DENTAL



Financial Policy

We are committed to providing you with the best possible dental care. Our fees reflect our professional commitment to excellence. In order to achieve these goals, we need your assistance and understanding of our payment and financial policy.

We offer the following methods of payment, Payment in full is due at the time of service.

- Cash, Check, Debit Card, MasterCard, Visa, Discover and American Express accepted.

For patients with insurance, we will accept payment directly from the insurance company, but require that the deductible and non-covered fees be paid at each visit.

We collaborate with Care Credit for a financing option. Applications can be completed online at www.carecredit.com or in office with the assistance of our receptionists.

If approved, print off approval with our account number and bring to your appointment.

Any parent/guardian bringing a child to our office is legally responsible for payment of all services rendered.

We do not bill individual parents for child's co-payment.

For your convenience, we provide patients with the option to authorize the use of their credit card. These authorizations allow California Dental to charge a patient's credit card for unpaid copays or account balances in our office without your presence but only after your consent.

Important Information Regarding Your Dental Benefits

Your dental benefit program is a contract between you, your employer, and the insurance company. We are not a party to that contract. This office files your insurance as a courtesy to you. Not all dental services are a covered benefit in all contracts.

It is your responsibility to know your benefits.

You (not the insurance company) are responsible to us for all our fees for services rendered to you. An **ESTIMATE** will be given of the benefits that the insurance company is expected to pay. Remember that this is only an **ESTIMATE** and that the actual cost may vary.

Broken/Missed appointment

Appointments reserve a specific time with the dentist or hygienist to perform and provide the care you need. These scheduled times are planned for your convenience and hold great value. We require 48-hour notice of canceling or rescheduling your appointment, if 48 hours' notice is not given a \$65.00 fee will be charged.

I acknowledge I have received and agreed to California Dental Payment & Financial Policies.

Patient or Responsible Party: _____

Date: _____

Signature: _____

CALIFORNIA DENTAL

1009 Glenoaks Blvd, San Fernando CA 91340
Phone 818.361.3889 | Fax 818.361.6280 | Email contact@california-dental.net
www.california-dental.net



General Dental Treatment Consent Form COVID-19 Pandemic

1. I knowingly and willingly consent to dental treatment by Dental Provider of California Dental Practice and any designated associates and employees during the COVID-19 pandemic.
2. I understand that Dental Provider of California Dental Practice is following CDC guidelines as far as treatment protocols and infection control.
3. I am unaware of being a possible carrier or infected: I confirm that I have not tested positive for COVID-19 in the last 30 days and that I am not presenting with any of the following symptoms of COVID-19:
 - a. Fever of 100.5 degrees Fahrenheit or 37 degrees Celsius or higher;
 - b. Shortness of breath;
 - c. Dry cough;
 - d. Runny nose;
 - e. E. Sore throat;
 - f. Diminished sense of taste and smell.
4. Contact with infected: I confirm that I have not knowingly been in close contact defined as 6 feet or less for a duration of fifteen minutes or more with someone who has tested positive for COVID-19 in the last 14 days, or with anyone that has had the above stated symptoms in the last 14 days.
5. Public travel: I confirm that I have not traveled outside of the United States in the past 14 days. I confirm that I have not traveled domestically by commercial airline, bus, or train within the last 14 days.
6. I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms yet are still highly contagious. It is impossible to determine who has it and who does not give the current limitations and availability in COVID-19 viral testing. I understand that numerous dental procedures create water spray which is one way the disease is spread. The ultra-fine nature of the spray can linger in the air for hours, which can transmit the COVID-19 virus.
7. Risk of transmission: I understand that due to the frequency of visits of other dental patients, characteristics of the virus, and the characteristics of dental procedures, that I may have an elevated risk of contracting the virus simply by being in a dental office, even though CDC and California Department of Public Health guidelines are being observed.

Informed Consent

I have been given the opportunity to ask any questions regarding the risks of contracting COVID-19 from the dental office and dental procedures. I reaffirm that I am not a carrier of COVID-19 nor infected with COVID-19 to the best of my knowledge. I do voluntarily assume all reasonable medical/dental risks, including the substantial and significant risk of serious harm, if any, which may be associated with any phase of my treatment as a result of the COVID-19 pandemic. I acknowledge that the nature and purpose of the dental procedures recommended have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient or Responsible Party: _____

Signature: _____

Date: _____

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