

**PATIENT INFORMATION**

**PLEASE PRINT AND FILL OUT FORM COMPLETELY.**

**DATE:** \_\_\_\_\_

**(Parent information if patient is a minor)**

NAME \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_ HOME PHONE( ) \_\_\_\_\_  
First Mi Last

ADDRESS \_\_\_\_\_ APT. # \_\_\_\_\_ CELL PHONE ( ) \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ WORK PHONE( ) \_\_\_\_\_ Ext: \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SS NUMBER \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ E-MAIL: \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_ EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

**DENTAL INSURANCE**

**NAME OF INSURED IF DIFFERENT THAN PATIENT:**

NAME \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE( ) \_\_\_\_\_ GROUP # \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SS NUMBER \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

POLICY / ID NUMBER \_\_\_\_\_

EMPLOYER \_\_\_\_\_

**DO YOU HAVE A SECONDARY DENTAL INSURANCE? YES \_\_\_\_\_ NO \_\_\_\_\_**

IF YES, PLEASE GIVE **SECONDARY DENTAL INSURANCE INFORMATION** TO FRONT DESK RECEPTIONIST.

IN CASE OF EMERGENCY, CONTACT: \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE #( ) \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? \_\_\_\_\_

**PATIENT TREATMENT CONSENT**

- I AUTHORIZE THE DENTIST(S) OR DESIGNATED STAFF TREATING ME TO PERFORM SUCH DIAGNOSTIC AIDS DEEMED APPROPRIATE TO MAKE A THOROUGH DIAGNOSIS OF MY DENTAL NEEDS.
- I ASSIGN ALL DENTAL INSURANCE BENEFITS TO WHICH I AM ENTITLED TO THE EXTENT PERMITTED UNDER MY DENTAL INSURANCE POLICY(S) TO THE DENTIST. THE FORM ALSO AUTHORIZES THIS PRACTICE TO SUBMIT INSURANCE CLAIM FORMS AND RECEIVE PAYMENT DIRECTLY FROM THE INSURANCE CARRIER WITH THE NOTATION "SIGNATURE ON FILE". I AUTHORIZE MY DENTIST(S) TO RELEASE TREATMENT RECORDS / X-RAYS OR ANY OTHER INFORMATION DEEMED PERTINENT TO MY INSURANCE CARRIER AS NECESSARY AND / OR REQUESTED.
- I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.
- PATIENTS WHO HAVE DENTAL INSURANCE SHOULD BE AWARE THAT DENTAL SERVICES ARE RENDERED AND CHARGED TO THE PATIENT, NOT THE INSURANCE COMPANY. OUR SECRETARY WILL BE PLEASED TO ASSIST YOU IN MAKING YOUR DENTAL INSURANCE CLAIMS BY COMPLETING AN ATTENDING DENTIST'S STATEMENT FOR SUBMISSION TO YOUR INSURANCE COMPANY.
- I HAVE ALSO RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES. I AM GIVING MY CONSENT TO USE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT ACTIVITIES AND HEALTH CARE OPERATIONS.

\_\_\_\_\_  
**PATIENT/PARENT OR GUARDIAN SIGNATURE**

\_\_\_\_\_  
**PRINT NAME PATIENT/PARENT OR GUARDIAN**

**DATE:** \_\_\_\_\_

# PATIENT HISTORY

Please print and fill out form completely.

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

ARE YOU HAVING ANY DISCOMFORT AT THIS TIME? YES NO

ANY SENSITIVITY TO:

COLD HOT SWEETS CHEWING

ARE THERE ANY SPECIAL PROBLEMS WHICH BROUGHT YOU IN TODAY? YES NO

IF YES, EXPLAIN: \_\_\_\_\_ DATE OF LAST DENTAL VISIT? \_\_\_\_\_

WAS THERE ANY PARTICULAR REASON WHY YOU LEFT YOUR PREVIOUS DENTIST?

DOES DENTAL TREATMENT MAKE YOU NERVOUS?

YES NO SLIGHTLY MODERATELY EXTREMELY

IS THERE ANYTHING ABOUT RECEIVING DENTAL CARE THAT CONCERNS YOU? YES NO

IF YES, EXPLAIN: \_\_\_\_\_

DO YOU HAVE ANY OF THE FOLLOWING?

BLEEDING GUMS BAD BREATH GRIND TEETH AT NIGHT CLICKING JAW

HOW OFTEN DO YOU BRUSH? \_\_\_\_\_

HOW OFTEN DO YOU FLOSS? DAILY SOMETIME RARELY

SEALANTS AND PREVENTATIVE RESIN RESTORATIONS: HAVE YOU HAD A SPECIAL COATING PLACED ON YOUR BACK TEETH TO PROTECT YOUR TEETH FROM DECAY? YES NO

IF I COULD CHANGE MY SMILE I WOULD: (CHECK ANY WHICH APPLY):

REPLACE STAINED FRONT FILLINGS CHANGE SILVER FILLINGS TO WHITE CLOSE SPACES  
REPAIR CHIPPED TEETH STRAIGHTEN SOME TEETH WHITEN MY TEETH OTHER \_\_\_\_\_

DO YOU HAVE OR HAVE YOU EVER HAD **REMOVABLE DENTAL APPLIANCES**? YES NO

IF YES, **WHEN WERE THEY MADE?** \_\_\_\_\_ DO YOU PLAY SPORTS? YES NO

WHEN WAS THE LAST TIME YOU HAD A DENTAL CLEANING? \_\_\_\_\_

NAME OF PREVIOUS DENTIST \_\_\_\_\_

WHEN WERE THE LAST FULL MOUTH X-RAYS TAKEN OF YOUR TEETH? \_\_\_\_\_

HOW WOULD YOU DESCRIBE YOUR DENTAL HEALTH?

EXCELLENT GOOD FAIR POOR

**MEDICAL HISTORY**  
PLEASE PRINT AND FILL OUT  
FORM COMPLETELY

DATE	DOCTORS INITIALS	CHANGE *YES NO	DATE	DOCTORS INITIALS	CHANGE *YES NO

**NAME:** \_\_\_\_\_  
First MI Last

\*If yes, update patient chart

(For office use only)

**DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?**

	YES	NO		YES	NO		YES	NO
* MITRAL VALVE PROLAPSE	___	___	KIDNEY PROBLEMS	___	___	BLEEDING DISORDERS	___	___
* HEART MURMUR	___	___	HEPATITIS	___	___	NERVOUS DISORDERS	___	___
HEART TROUBLE	___	___	JAUNDICE	___	___	MENTAL DISORDERS	___	___
PACEMAKER	___	___	* JOINT REPLACEMENTS	___	___	HIV+	___	___
* HEART VALVE SURGERY	___	___	EXCESSIVE BLEEDING	___	___	ASTHMA	___	___
HEART BYPASS SURGERY	___	___	TUBERCULOSIS	___	___	SINUS PROBLEMS	___	___
* RHEUMATIC FEVER	___	___	LUNG PROBLEMS	___	___	HIVES OR RASHES	___	___
DIABETES	___	___	STROKE	___	___	FAINING SPELLS	___	___
HIGH BLOOD PRESSURE	___	___	EPILEPSY	___	___	VENEREAL DISEASE	___	___
LIVER PROBLEMS	___	___	SEIZURES	___	___	LATEX ALERGY	___	___
						OTHERS	___	___

**ARE YOU TAKING ANY DRUGS OR MEDICATIONS? YES \_\_\_ NO \_\_\_ IF YES, WHAT?**

MEDS: \_\_\_\_\_ FOR: \_\_\_\_\_ MEDS: \_\_\_\_\_ FOR: \_\_\_\_\_  
MEDS: \_\_\_\_\_ FOR: \_\_\_\_\_ MEDS: \_\_\_\_\_ FOR: \_\_\_\_\_

HAVE YOU EVER TAKEN BISPHTHOSPHONATES? YES \_\_\_ NO \_\_\_

\* DO YOU NEED TO TAKE ANTIOTBIOTIC PREMEDICATION PRIOR TO DENTAL APPOINTMENT? YES \_\_\_ NO \_\_\_

ARE YOU ALLERGIC TO ANY MEDICINE OR ANESTHETIC? YES \_\_\_ NO \_\_\_  
IF YES, WHAT? \_\_\_\_\_

DO YOU HAVE OR HAVE YOU EVER HAD ANY PROBLEMS WITH LOCAL ANESTHETICS? YES \_\_\_ NO \_\_\_

ARE YOU IN GOOD HEALTH? YES \_\_\_ NO \_\_\_

ARE YOU CURRENTLY SEEING A MEDICAL DOCTOR? YES \_\_\_ NO \_\_\_  
IF YES, WHAT IS BEING TREATED? \_\_\_\_\_

MEDICAL DOCTOR'S NAME \_\_\_\_\_ PHONE # \_\_\_\_\_

HAVE YOU HAD ANY SERIOUS ILLNESS OR HOSPITALIZATIONS? YES \_\_\_ NO \_\_\_  
IF YES, PLEASE EXPLAIN: \_\_\_\_\_

ARE YOU TAKING ASPIRIN DAILY? YES \_\_\_ NO \_\_\_

IS THERE ANY CONDITION OR PROBLEM RELATING TO YOUR MEDICAL HISTORY THAT HAS NOT BEEN MENTIONED? YES \_\_\_ NO \_\_\_  
IF YES, EXPLAIN: \_\_\_\_\_

IS THERE ANY ADDITIONAL INFORMATION THAT SHOULD BE NOTED BY YOUR DENTIST? \_\_\_\_\_

IF YOU ARE A FEMALE ANSWER THE FOLLOWING:  
ARE YOU PREGNANT? YES \_\_\_ NO \_\_\_  
ARE YOU TAKING ORAL CONTRACEPTIVES? YES \_\_\_ NO \_\_\_

\_\_\_\_\_  
**PATIENT SIGNATURE (parent or guardian if patient is a minor)** **DATE**

-----\*For office use only\*-----  
FOR DOCTOR / HYGIENIST: MEDICAL ALERT RECOMMENDED? YES \_\_\_ NO \_\_\_ IF YES, PLACE STICKER IN CHART AND ON CHART COVER

DATE	INTERVIEWERS NOTES

**DENTAL MATERIALS FACT SHEET/ACKNOWLEDGMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES/CONSENT FOR USE AND DISCLOSURE OF  
HEALTH INFORMATION.**

By far, the most commonly used materials in restorative dentistry are gold, porcelain, composites, and amalgam. Each has its own advantages and disadvantages, risks and benefits. Each restorative material contains some ingredients which may preclude its use on some patients who have sensitivities, allergies, or other special health care needs. Information contained in this fact sheet is intended to encourage discussion between the patient and dentist in the selection of dental materials best suited to the patient's dental health. It is not intended to be a complete guide to dental materials science.

Dental amalgam, used as a primary dental restorative material for over 150 years, is composed of numerous metals mixed together in varying percentages (43 to 54 percent liquid mercury and 46 to 57 percent alloy powder). The mercury component allows for the other metals in the alloy powder (largely silver, copper and tin) to form the "amalgam". Although elemental mercury has been known to be a toxic substance, it was long believed that once it became bound to the metals in the amalgam, it lost its toxicity. Recent research, however, has shown that minute amounts of free mercury can escape from amalgam filling and be absorbed by the body during placement, adjustment, or by vigorous chewing. The preponderance of scientific evidence, to date, fails to show that exposure to mercury from amalgam restoration poses a health risk, except for a small number of allergic and/or sensitive patients.

Direct composite fillings have become an acceptable alternative for dental amalgam when used appropriately. Composites are comprised of numerous elements such as dimethacrylates, bisphenol compounds and beryllium. Some elements contained in composites have been determined to be cytotoxic and carcinogenic. Since the use of composites as a restorative material is relatively new, scientific research has not yet determined the long term benefits or risks involved. However, composites are gaining wider acceptance as a restorative material.

In contrast to the above restorative materials, research has uncovered no health hazards from cast gold or porcelain restorative materials (aside from allergies). However, some non precious alloys used in place of gold or porcelain have been known to cause sensitivities or allergic reaction in small percentage of patients. Patients should be aware of the risks when choosing these options.

Restorative materials such as composite and amalgam fillings and crowns, orthodontic appliances such as brackets and wires, and other materials used in dental treatment contain chemicals known to the State of California to cause cancer, birth defects, or other reproductive harm.

I have read and understood this information. I have been given a copy of the Dental Board of California Dental Materials Fact Sheet.

I have also received a copy of this office's notice of privacy practices. I am giving my consent to use disclosure of my protected health information to carry out treatment, payment activities and health care operations.

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

## INFORMED CONSENT

### Crowns, Bridges and Fillings

Dental crowns are restorations that cover or cap teeth. They may restore teeth to their natural size, shape and color. A crown may help with appearance and can strengthen a tooth as well.

A fixed, or stationary bridge is designed to replace teeth that have been lost. Missing teeth may need to be replaced for appearance, to prevent or correct bite, to prevent gum problems related to shifting or stressed teeth, and to increase chewing efficiency.

Sometimes a crown covering the entire tooth is not necessary and a gold filling, silver filling, or white filling is required.

Dental crowns and bridges are made of porcelain and usually have an inner layer of metal. Some may be made of metal alone. For teeth with large fillings or large cavities or decay below the gums, a dental crown may be recommended.

A silver filling or dental amalgam is a metallic substance composed of silver, tin, copper, zinc, and mercury. Silver fillings may turn dark, discolor teeth, or fracture. They may be recommended to restore small to medium cavities. Amalgam fillings contain a chemical element known to the State of California to cause birth defects or other reproductive harm.

Gold fillings or cast gold alloys contain mostly gold. They do not darken or discolor teeth. They generally do not break or fracture but occasionally may loosen. They may be recommended to restore small to large cavities or damaged teeth.

White fillings are generally made of composite. They may be used in small cavities that do not go below the gum.

Because of their more accurate fit and biocompatibility precious metal or gold are usually recommended as the material of choice for metal crowns or the inner layer of metal for porcelain crowns. Most insurance have additional patient co-payments for using precious metal or gold. Most insurance have additional co-payments for using porcelain on molar teeth (back teeth). Your estimate has included the additional charge for precious metal, gold or porcelain on molars, if applicable.

As with all procedures, there are certain potential problems associated with crowns, bridges and fillings. These include, but are not limited to:

1. The potential need for **root canal therapy**. The cumulative effects of cavities, fillings and cracks in the teeth may necessitate a root canal. The need for root canal may become apparent during a crown preparation, or after a crown is made. Even after root canal therapy, teeth sometimes need to be extracted.
2. **Periodontal (gum) disease** can occur at any age, with or without fillings, crowns and bridges. Generally speaking crowns and bridges do not create or prevent gum disease.
3. **Fracture** to the porcelain or tooth may occur after placement. Small fractures may be repaired; large fractures may require a new crown, bridge or extraction.
4. **Dark lines at the gum line** may appear on crowns or fixed bridges. This is the metal edge of the crown. If the gum recedes after placement, this metal will show. Sometimes this can be corrected, other times a new crown or bridge might be needed.
5. **Recurrent tooth decay** can occur after placement. This may be corrected with a filling or a new crown or bridge might be needed. At times, an extraction may be required.
6. **Food impaction** may occur under a bridge. This may be unavoidable condition. Meticulous home care is required.

**I have read and understood this information.**

\_\_\_\_\_  
Patient Signature(parent or guardian if a minor)

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Date