WE WOULD LIKE TO GET TO KNOW YOU BETTER!

DATE CHART#

PATIENT

Name: ____ Date of Birth __ __ / __ __ / __ __

Address City: ____ Apt. # ________

City ______________ State: ____________ Zip Code __________

Phone Number…

House: (____) ____-_____ Cell: (____) ____-_____ Work: (____) ____-______

Social Security: Sex: (M) (F) Email Address ________________

I.D/Drivers License#: ______________________ Marital Status: _________________________

Emergency Contact: Name_________________ Phone # __________________

Employer Name: Occupation:

Employer Address: City: ______________State_____Zip ______

How did you hear about us?____

RESPONSIBLE PARTY (if applicable)
INSURANCE INFO

Name:____ Date of Birth: __ __ /__ __ /__ __

Address:____ Apt# ________

City:_________________________________ State:_______________Zip Code: ________

Telephone #:__________________________ Social Security: ________________________

Employer:_____________________________ Phone Number: ____________________________

Name of Insurance Co: __________________________ Phone#_____________________________

PERSONAL REFERENCES

I. Name:___________________________________ Phone Number________________________

Relationship to patient: ________________________

2. Name:___________________________________ Phone Number________________________

Relationship to patient: ________________________

How do you intend to pay for today's visit? Insurance Medi-cal Cash/Credit Other

We would like to take care of your needs first...

Any present dental problems?

Are you satisfied with your teeth and their appearance? Yes No

Does dental treatment make you nervous? Yes No

I think my dental health is……… [ ] excellent [ ] good [ ] fair [ ] poor

If I could, I would make my teeth…. [ ] whiter [ ] straighter [ ] healthier

[ ] other Please Explain: ____

I hereby certify that the information above is accurate. I understand that I am financially responsible for the charges not covered by or paid for by my insurance company. I hereby authorize payment directly to this dental professional from my insurance co.

______________________________________ ______________________

signature date

HEALTH HISTORY / HISTORIA DE SALUD

DATE / FECHA____-_____-____

AGE / EDAD ________ SEX / SEXO M / F

HEIGHT /ESTATURA___________ WEIGHT/PESO LBS. ____________

Facility _____________ Chart# ___________(LABEL)

Patient N a m e ____

In case of an emergency, contact (person)____ phone # ( )_______ ______________

En caso de emergencia, contactar a (persona) ______________________________Numero de telefono: ( )_______ ______________

INSTRUCTIONS:
Answer all questions and fill in the blank spaces when indicated. Answers to the following questions are for our records only and will be kept confidential.

INSTRUCCIONES: Conteste todas las preguntas y llene los espacios en blanco cuando sea necesario. Las respuestas a nuestras preguntas son unicamente para nuestros archives, y se consideran estrfctamente confidenciales.

Why are you here today?

When was your last visit to a dental office?

When were your last dental x-rays taken?

Are those x-rays available? O Yes O No

If YES please write down PRIOR DENTIST'S NAME and PHONE NUMBER:

( )

6 P6rque esta aqui ahara? ______________________________________

6 Cuando fue su ultima visita al dentista? ______/______/______

6 Cuando le tomaron las ultimas radiografias dentales? ______/______/______

6 Estan disponible sus radiografias? O Si O No

Si es asi, escriba el nombre del Dentista Anterior y el numero de telefono.

( )

	YES / SI	NO
1. Are you in poor health	______	______
2. Has there been any change in your general health within the past year	______	______
3. My last physical was on ______________		
4. Are you currently under the care of a physician	______	______
A. If so. what is the condition being treated __________________		
5. The name and address of my physician is ____________________ ____________________		
6. Have you had any serious illness or operation	______	______
A. If so, what was the illness or operation __________________ ____________________		
7. Have you been hospitalized or had a serious illness within the past five years	______	______
A. If so, what was the problem ____________ ____________________		
8. Do you have or have you had any of the following diseases or problems:		
A. Damaged heart valves or artificial heart valves	______	______
B. Congenital heart lesions or murmurs	______	______
C. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)	______	______
1) Do you have pain in chest upon exertion	______	______
2) Are you ever short of breath after mild exercise	______	______
3) Do your ankles swell	______	______
4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep	______	______
5) Do you have a cardiac pacemaker	______	______
D. Sinus trouble	______	______
E. Asthma	______	______
F. Allergy	______	______
G. Hives or skin rash	______	______
H. Fainting spells or seizures	______	______
I. Diabetes	______	______
1) Do you urinate (pass water) more than 6 times a day	______	______
2) Are you thirsty much of the time	______	______
3) Does your mouth frequently become dry	______	______
J. Hepatitis, jaundice or liver disease	______	______
K. Arthritis		
L. Inflammatory rheumatism (painful, swollen joints)		
M. Stomach ulcers	______	______
N. Kidney trouble	______	______
O. Tuberculosis		
P. Do you have a persistent cough or cough up blood		
Q. Low blood pressure		
R. Venereal disease	______	______
S. Do you have a prosthetic hip ____ joint prosthesis ____ implants ____ bone plates ____ or screws ____other ______________________	______	______
9. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma	______	______
A. Do you bruise easily	______	______

1. Esta mal de salud
2. Ha cambiado su salud durante el ultimo afio
3. Mi ultimo examen medico fue en ______________________
4. Esta ahara bajo atenci6n medica
   A. Sf es asf, que enfermedad se esta curando ____________
5. El nombre y domicilio de mi medico es ______________________ ______________________
6. Ha tenido alguna operaci6n o enfermedad seria
   A. Si es asi, que operaci6n o enfermedad ______________ ______________________
7. Durante los ultimos cinco (5) aiios ha sido hospitalizado 6 ha tenido alguna enfermedad seria
   A. Si contesta afirmativamente explique ________________ ______________________
8. Tiene o ha tenido alguna de las siguientes enfermedades 6 problemas:
   A. Valvulas daiiadas 6 valvulas artificiales del coraz6n
   B. Lesi6n cardiaca congenita
   C. Enfermedad cardiovascular (enfermedad del coraz6n, insuficiencia cardiaca, oclusi6n coronaria, presi6n arterial alta, arteriosclerosis, sincope)
      1) Tiene dolor en el pecho cuando hace algun esfuerzo
      2) Despues de hacer algun ejercicio siente faltarle el aire
      3) Se le hinchan los tobillos
      4) Cuando se acuesta, siente que le falta aire para respirar 6 necesita mas de 1 almohada para dormir
      5) Tiene marcapasos cardfaco
   D. Problema de senusitis
   E. Asma
   F. Alergia
   G. Ronchas 6 salpullido
   H. Desmayos y sudores 6 ataques
   I. Diabetes
      1) Orina usted mas de seis veces al dfa
      2) Tiene sed la mayoria del tiempo
      3) Se le reseca la boca frecuentemente
   J. Malestar bilioso, hepatitis o enfermedad del higado
   K. Artritis
   L. Inflamaci6n reumatica (coyunturas inflamables con dolor)
   M. Ulceras estomacales
   N. Enfermedad del riii6n
   O. Tuberculosis
   P. Tos persistente 6 tose sangre
   Q. Baja presi6n sanguinea
   R. Enfermedades venereas
   S. Tiene cadera _____6 coyuntura prostetica ______ implantes _____placa de hueso ______6 tornillos ______
      Si es asi, explique ______________
9. Ha sangrado anormalmente, cuando se le realiza una extracci6n dental, cirujfa 6 trauma
   A. Se moretea su piel facilmente

	YES / SI	NO
B. Have you ever required a blood transfusion If so, explain the circumstances ______________________	____	____
10. Do you have any blood disorder such as anemia	____	____
11. Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your mouth or lips	____	____
12. Are you taking any of the following: If yes, indicate which. A. Antibiotics or sulfa drugs _____ B. Anticoagulants (blood thinners) _____ C. Medicine for high blood pressure _____ D. Cortisone (steroids) _____ E Tranquilizers _____Antihistamine ______Aspirin ______ F. Insulin, tolbutamide (orinase) or similar drug _____ G Digitalis or drugs for heart trouble _____Nitroglycerin ______ H. Oral contraceptive or other hormonal therapy _____ I Other drug or medicine ____________________	____	____
13. Are you allergic or have you reacted adversely to any of the following: Local anesthetics Pentcillln or other anttbtotics Sulfa drugs _____ Barbiturates, sedatives or sleeping pills _____ Aspirin _____Iodine ______Codeine or other narcotics ______	____	____
Are you allergic to latex or rubber products	____	____
Other allergies ____________________		
14. Have you taken the diet medication Redux® (Fen-Phen)?	____	____
15. Do you have any disease, condition, or problem not listed above that you think I should know about	____	____
16. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation		____
17. Are you wearing contact lenses	____	____
18. Have you ever had any of the following conditions Herpes _____Hepatitis ______Tuberculosis ______ HIV / AIDS	____	____
19. Are you pregnant	____	____
20. Do you have any problems associated with your menstrual period	____	____
21. Are you nursing	____	____
22. Have you had any serious trouble associated with any previous dental treatment If so, explain ____________________	____	____
23. How often do you brush your teeth? _______When? ______________		
24. Do you use dental floss	____	____
25. Do your gums bleed or hurt? How often? ____________________	____	____
26. Are any of your teeth sensitive to: Hot _____Cold ______ Sweets Pressure		
27. Does food get caught in your teeth?	____	____
28. Do you have frequent headaches _____neck aches _____ or shoulder aches?	____	____
29. Do you clench or grind your teeth?	____	____
30. Have you experienced any pain or soreness in the muscles of your face or around your ear?	____	____
31. Does your jaw click or pop?	____	____

B. Ha requerido transfusion sanguinea
Si contesta afirmativamente, explique ______________

10. Tiene algun desorden sanguineo tal como anemia
11. Ha tenido cirujia 6 rayos X para tratar algun tumor, crecimiento u otra enfermedad bucal o labial
12. Esta tomando alguno de los siguientes medicamentos:
A. Sulfas o antibioticos
B. Anticoagulantes (adelgazador sanguineo) _____
C. Medicamento para la presion alta _____
D. Cortisona (esteroides) _____
E. Tranquilizantes ____Antihistaminico ______Aspirina ______
F. Insulina, tobultamida (orinase) o drogas similares _____
G. Digitales o medicamentos para enfermedades cardiacas_____
Nitroglicerina _____
H. Anticonceptivos orales u otra terapia hormonal _____
I. Otra droga o medicina ______________
13. Es usted ah rgico o ha reaccionado adversamente a los siguientes medicamentos:
Anestesia local _____Antibioticos o penicilina ______
Drogas con sulfas _____
Barbituricos, sedantes o pastillas para dormir _____
Aspirina _____Yodo ______Codeina u otros narcoticos ______
Es usted alergico al latex o productos de hule _____
Alguna otra ______________
14. Ha tomado usted el medicamento Redux® (Fen-Phen) para su dieta.
15. Tiene usted alguna enfermedad condicion fisica o algun problema no enumerado anteriomente que usted crea que yo deba saber
16. Esta trabajando o esta en una situacion donde esta expuesto regularmente a radiografias o alguna otra forma de radiacion
17. Usa lentes de contacto
18. Ha tenido alguna de las condiciones siguientes:
Herpes_ Hepatitis_ Tuberculosis_ HIV / SIDA ___
19. Esta usted embarazada
20. Tiene algun problema asociado con su periodo menstrual
21. Esta dando pecho (amamantando)
22. Ha tenido problemas series asociadas con tratamiento dental.
Si contesta afirmativamente, explique. ______________
23. Que tan seguido se cepilla los dientes _____Cuando ______
24. Usa hilo dental
25. Le sangran o le duelen sus encfas
Que tan seguido ______________
26. Son su dientes sensibles a: Caliente _____Frfo ______
Dulce Presion
27. Retiene comlda en sus dlentes
28. Tlene dolores de cabeza _____cuello ______
u hombre frecuentemente _____
29. Aprieta o rechina sus dlentes
30. Ha tenldo algun dolor en los mllsculos de la cara o alrededor de los ofdos
31. Suena 6 cruje su quljada

FOLLOW UP to Medical History by DENTIST ONLY ____________________

I hereby certify that I have read the foregoing and have filled out this health questionnaire completely. I have advised you of all medical problems of which I am aware. I further certify that I, the undersigned, consent to the performing of x-rays and examination.

Por la presente certifico que he leido y completado el cuPstionario de salud totalmente. He dado a conocer los trastornos de los que tengo conocimiento. El suscrito certifica y da su consentimiento para que se realicen los rayos X y el examen necesario.

SIGNATURE OF **PATIENT or Guardian** if patient is a minor
FIRMA DEL **PACIENTE** 6 del **tutor legal** (si el paciente es menor de edad) X ____________________ **DATE (Fecha)**______________

SIGNATURE OF **DENTIST** (FIRMA DEL **DENTISTA**) X ____________________ **DATE (Fecha)** ______________

DATE	COMMENTS	DR. SIGNATURE	EMPLOYEE #	PATIENT SIGNATURE
UPDATE				

Form 041 (Rev.OS/00)
C Copynght Western Dental Serv ces.Inc.
C1ty Data Supply. Inc. (714) 556-5tt1

Notice of Privacy Practices
Acknowledgement and Consent

Northridge DentalWorks
18433Roscoe Blvd Suite 201
Northridge, CA 91325
(818) 882-0100

Section A: Patient Information

____
Patient Name

______________________________ __________ __________ __________
Street Address

______________________________ (_______) ______________________
City, State. Zip Code

Section B: To the Patient- Please Read the Following Statements Carefully

Purpose of Consent: By signing this form. you will consent to our use and disclosure of your protected health information to carry out treatment payment activities. and healthcare operations.

Notice of Privacy Practices: You have the right to read our notice of privacy practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment. payment activities. and healthcare operations of the uses and disclosures We may make of your protectected health information. and of other important matters about your protected health information. A copy Of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our notice: of privacy practices. Such changes may apply to any of your protected health information that we maintain. If we change our privacy practices. we will revise the notice of privacy practices and make the new Notice available upon request.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the privacy officer listed at the end of the notice of privacy practices. Please understand that revocation of this Consent will not affect any action we took in reliance on this consent before we receive your revocation. and that we may decline to treat you or to continue treating you if you revoke this consent.

Section C: Patient Representative Signature

I,______________________________ , have n::ceivc:d a copy of this Office's Notice of Privacy Practices. I Have had full opportunity to read and consider the contents of this Consent Form and the: Notice of Privacy Practices. I understand that. by signing this Consent form. I am giving my consent to your use and disclosure of my protected health information. or the protected health information of the patient I am representing to carry out treatment payment activities. and health care operations.

______________________________ ____________________
Signature Date

••Jf this Consent is signed by a representative on behalf of the patient. complete the following:

______________________________ ____________________
Patients Name **Relationship to Patient**

Section S: Revocation of Consent

*****only sign the section if you wish to revoke your consent *****

I revoke my consent for your use and disclosures of my protected health intormation or that of the patient I am representing, for Treatment. payment activities and healthcare operations. I understand the revocation of my consent will not affect any action You took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline To treat or to continue to treat me. or the patient I am representing atier I have revoked my Consent.

______________________________ ____________________
Signature Date

Patient Acknowledgment of
Receipt of Dental Materials Fact Sheet

I ______________________, acknowledge I have

Received from ______**Northridge DentalWorks**________ a copy of the
Dentist office name
Dental Materials Fact Sheet dated October 2001.

_______________________________ _______________
Signature Date

Sample

The following document is the dental board of California's Dental Materials Fact Sheet. The Department of consumer affairs has no position with respect to the language of this Dental Material Fact Sheet and its linkage to the DCA web site does not constitute an endorsement of the content of this document

The Dental Board of California

Dental Materials Fact Sheet

Adopted by the Board on October 17, 200 I

As required by chapter 801, Statutes of 1992, the dental Board of California has prepared this fact sheet to Summarize information on the most frequently used restorative dental materials. Information on this shed Is intended to encourage discussion between the patient and the dentist regarding the selection of dental materials but suited for the patient's dental needs. It is not intended to be a complete guide to dental materials science.

The most frequently used materials in restorative dentistry are amalgam, composite resin, glass ionomer Cement resin-ionomer cement, porcelain (ceramic), porcelain (fused to metal), gold alloys (noble) and nickel or cobalt-chrome (base metal) alloys. Each material has its own advantages and disadvantages, benefits and risks. These and other relevant factors are compared in the attached matrix titled "Comparisons" of Restorative Dental Materials. "A glossary of terms" is also attached to assist the reader in understanding the terms used.

The statements made are supported by relevant, credible dental research published mainly between 1993-2001 In some cases, where contemporary research in sparse. we have indicated our best perceptions based upon information That predates 1993.

The reader should be aware that the outcome of dental treatment or durability of a restoration is not solely a function of the material
From which the restoration was made. The durability of any restoration is influenced by the dentist's technique when placing the restoration, the ancill11ry materials used in the procedure. and the patient's cooperation during the procedure. Following restoration of the teeth, the longevity of the restoration will be strongly influenced by the patient's compliance with dental hygiene and home care, their dirt and chewing habits.