# Kool Dental

*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.

| | | |
|---|---|---|
| ☐Zoom! One-hour Teeth Whitening | ☐Veneers/Lumineers | ☐Bonding |
| ☐Take-home Bleaching Trays | ☐Smile Makeover | ☐Implant Crowns |
| ☐Partials/Dentures | ☐Crowns & Bridge | ☐Replace Silver Fillings |
| ☐Nightguard/Sportsguard | ☐Sealants | ☐Straighter Teeth |
| ☐Bad Breath | ☐Fixing Chipped Teeth | |

# *Kool Dental*

*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: ☐ Policy Holder ☐ Responsible Party ☐ Child

Address: _____ City, State and Zip: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Email Address: _____

Birth Date: _____ Soc. Sec: _____ Drivers Lic: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Self Employed ☐ Other Gender: _____

Marital Status: ☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other

Student Status: ☐ Full Time ☐ 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: ☐ Full Time ☐ Part Time ☐ Retired ☐ Self Employed ☐ Other Gender: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other

**PRIMARY INSURANCE (IF APPLICABLE, PLEASE FILL OUT COMPLETELY)**

Name of Insured: _____ Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ 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: ☐ Self ☐ Spouse ☐ Child ☐ 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 ALERGIC TO THE FOLLOWING…**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Aspirin | ☐ Yes ☐ No | Acrylic | ☐ Yes ☐ No | Metal | ☐ Yes ☐ No | Local Anesthetics | ☐ Yes ☐ No |
| Penicillin | ☐ Yes ☐ No | Codeine | ☐ Yes ☐ No | Latex | ☐ Yes ☐ No | | |

Other, please explain: _____

**DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING…**

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

_____

_____

_____