Smiles of Temecula
Dental Group

Patient Information

Patient name: _____ (Last / First / M) E-mail: _____ Date: _____

Address: _____ (Street / Apt. # / City / State / Zip)

Birthdate: _____ Home phone: _____ Work phone: _____ Cell phone: _____

Height: _____ Weight: _____ Sex: ◯ M ◯ F Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Seperated

If student, _____ ☐ Full time ☐ Part-time

Patient's Employer: _____ Occupation: _____ SS#: _____

Business Address: _____ (Street / Suite # / City / State / Zip)

Spouse name: _____ Employer: _____ Work Phone: _____

Person to contact in case of emergency: _____ Relationship: _____ Phone: _____

If you are completing this form for another person, what is your relationship to that person? _____

Whom may we thank for referring you to our office? _____

Name of the person responsible for this account: _____ Relationship to patient: _____

Address (if different from above): _____

Birthdate: _____ Telephone: Home: _____ Work: _____

SS #: _____ Driver's License #: _____

Primary dental coverage information. If you do NOT have primary dental coverage, please check this box: ☐

Name of Insured: _____ Relationship to Patient: _____ Birthdate: _____

Address (if different from above): _____

SS #: _____ Driver's License #: _____ Date Employed: _____

Employer: _____ Union or local #: _____ Telephone: Work: _____ Home: _____

Address of Employer: _____

Dental Ins. Company: _____ Group #: _____ Policy ID #: _____

Secondary dental coverage information. If you do NOT have secondary dental coverage, please check this box: ☐

Name of Insured: _____ Relationship to Patient: _____ Birthdate: _____

Address (if different from above): _____

SS #: _____ Driver's License #: _____ Date Employed: _____

Employer: _____ Union or local #: _____ Telephone: Work: _____ Home: _____

Address of Employer: _____

Dental Ins. Company: _____ Group #: _____ Policy/ID #: _____

Dental History

Do you have a specific dental problem or chief complaint? Describe: _____ Yes No

Do you have dental examinations on a routine basis? When was your last visit? _____ Yes No

Do you think you have cavities or gum disease? _____ Yes No

Do you brush and floss on a routine basis? Describe: _____ Yes No

Do your gums ever bleed? Describe: _____ Yes No

Are you interested in any cosmetic procedures? ◯ Veneers ◯ Bonding ◯ Bleaching ◯ Braces ◯ Other: _____

Do you want to keep your remaining teeth? _____ Yes No

Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No

Have your past experiences in a dental office been positive? _____ Yes No

Name of previous dentist: _____ Date of last full mouth x-ray series: _____ Yes No

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Date: _____ Signature: _____

If patient is a minor, include printed name and signature of legal parent or guardian.

DO NOT WRITE IN THIS SPACE

Date: _____ Reviewed by: _____ Dentist's comments: _____

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Health History

Patient name: _____ Patient #: _____ Date: _____

Please answer each question by checking the appropriate box or circling Yes or No.:

1. Are you in good health? Yes No
2. Date of last physical examination: _____
3. Are you now under the care of a physician? Yes No

If yes, what is the condition being treated?

Doctor's name: _____ Telephone #: _____

4. Have you ever had any serious illness or operation or been hospitalized? Yes No
   Please explain:
5. Are you taking any medication? Yes No
   If yes, please provide names of all medication (or provide medicine list): _____
6. Are you using any recreational drugs (e.g., marijuana, cocaine) or controlled substances? Yes No
   If yes, what?
7. Have you ever been premedicated with antibiotics for your dental treatment? Yes No
8. Are you sensitive or allergic to any drugs or materials? ☐ Penicillin ☐ Tetracycline ☐ Erythomycin ☐ Sulfa

☐ Aspirin ☐ Latex ☐ Other If other, please list: _____ Yes No

9. Do you have or have you had any of the following: Please check "Y" for Yes or "N" for No - answer all conditions:

AIDS	○Y ○N	Cortisone Medicine	○Y ○N	Hemophilia	○Y ○N	Respiratory disease	○Y ○N
Allergies or Hives	○Y ○N	Diabetes	○Y ○N	Hepatitis or Jaundice	○Y ○N	Rheumatic Fever	○Y ○N
Allergies to Metals	○Y ○N	Difficulty in Swallowing	○Y ○N	Herpes	○Y ○N	Rheumatism	○Y ○N
Anemia	○Y ○N	Drug addiction	○Y ○N	High blood pressure	○Y ○N	Sickle cell disease	○Y ○N
Angina Pectoris	○Y ○N	Emphysema	○Y ○N	HIV Positive	○Y ○N	Sinus trouble	○Y ○N
Arthritis	○Y ○N	Epilepsy or Seizures	○Y ○N	Joint replacement	○Y ○N	Stomach Ulcers	○Y ○N
Artificial Heart Valve	○Y ○N	Excessive Bleeding	○Y ○N	Kidney disease	○Y ○N	Stroke	○Y ○N
Asthma	○Y ○N	Fainting Spells or Seizures	○Y ○N	Liver disease	○Y ○N	TMJ	○Y ○N
Blood Disease	○Y ○N	Glaucoma	○Y ○N	Mental disorder	○Y ○N	Thyroid disease	○Y ○N
Blood Transfusion	○Y ○N	Hay Fever	○Y ○N	Mitral valve prolapse	○Y ○N	Tonsillitis	○Y ○N
Bruise Easily	○Y ○N	Head Injuries	○Y ○N	Nervous disorders	○Y ○N	Tuberculosis	○Y ○N
Chemotherapy	○Y ○N	Heart ailments or attack	○Y ○N	Pain in jaw joints	○Y ○N	Tumors or growths	○Y ○N
Cold sores	○Y ○N	Heart failure	○Y ○N	Psychiatric treatment	○Y ○N	Venereal disease	○Y ○N
Congenital Heart Lesions	○Y ○N	Heart murmur	○Y ○N	Radiation treatment	○Y ○N		

10. Do you wear a cardiac pacemaker, or have you had heart surgery? If yes, please explain: _____ Yes No
11. Do you smoke, chew, use snuff or any other forms of tobacco? ○ Cigarettes ○ Cigars ○ Chew ○ Snuff ○ Other Yes No
    If yes, how much? _____
12. Do you consume alcoholic beverages? If yes, how much? _____ Yes No
13. Have you ever taken the drug, "Fen-phen" or "Redux"? Yes No
14. Have you ever taken biophosphonate medications like "Fusomax"? Yes No
15. Are you pregnant? If yes, how many months? _____ Yes No
16. Do you have any problems associated with your menstrual period?
17. Do you take birth control pills? Yes No
18. Is there anything we should know about your health that is not mentioned above?

Please explain: _____

1st. I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

DATE: _____ SIGNATURE: _____

(IF PATIENT IS A MINOR, INCLUDE PRINTED NAME AND SIGNATURE OF PARENT OR LEGAL GUARDIAN)

2nd. UPDATE - Since your last visit....

1. Have you seen a medical doctor? ..... Yes No
2. Have you had a change in any medication? ..... Yes No
3. Have you had a change in any medical condition or had surgery? ..... Yes No

If yes, please explain: _____

Date: _____ Signature: _____

3rd. UPDATE - Since your last visit....

1. Have you seen a medical doctor? ..... Yes No
2. Have you had a change in any medication? ..... Yes No
3. Have you had a change in any medical condition or had surgery? ..... Yes No

If yes, please explain: _____

Date: _____ Signature: _____

DO NOT WRITE IN THIS SPACE

DATE	B.P.	PULSE	REVIEWED BY	DENTIST'S COMMENTS
_____	___/___	_____	_____	_____
_____	___/___	_____	_____	_____

Smiles of Temecula
Dental Group

Examination	Patient
X-rays	Date

Tooth	Recommendation	Present	Reason
1			
2			
3			
4A			
5B			
6C			
7D			
8E			
9F			
10G			
11H			
12I			
13J			
14			
15			
16			
17			
18			
19			
20K			
21L			
22M			
23N			
24O			
25P			
26Q			
27R			
28S			
29T			
30			
31			
32			

I give my permission to Smiles of Temecula dental group to perform the necessary dental work stated in this treatment plan (Diagnosis) as explained and I am financially responsible.

Date: _____

Signature: _____

Occlusion type

Perio Type

Buccal mucosa

Lip

Tongue

Soft Palate

Hard Palate

T.M.J

Cancer

PERIO

Inflammation	Calculus	Oral hygiene	Deep scaling & Root Planning	Diagnosis
☐ Severe ☐ Moderate ☐ Light ☐ None	☐ Heavy ☐ Moderate ☐ Light ☐ None	☐ Low ☐ Fair ☐ Good	U.L. R.R. L.L. L.R.	

OTHER

☐ Prophylaxis
☐ Fluoride
☐ Bleeching
☐ Habit appliance
☐ TMJ

REMARKS

		Existing	Condition	Age	Paid by	Recommendation	Alternative	Accepted
Denture	Lower							
	Upper							
Partial	Lower					TEETH: CLASPS:		
	Upper					TEETH: CLASPS:		
Stayplate	Lower					TEETH: CLASPS:		
	Upper					TEETH: CLASPS:		

Signature of patient: _____ Date: _____ Signature of Doctor: _____ Date: _____

Dental Treatment Consent Form

Please read and initial the items checked below
and read and sign the section at the bottom of the form.

Patient name: _____

○ 1. Work to be done

I understand that I am having the following work done: Fillings _____ Bridges _____ Crown _____ Extractions _____
Impacted teeth removed _____ General anesthesia _____ Root canals _____ Other _____

(Initials _____)

○ 2. Drugs and medications

I 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).

(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 routing 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 eplained to me (root canal therapy, crowns, 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, loss of feeling in my teeth, lips, tongue, and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand 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 _____)

○ 5. Crown, 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 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 (including shape, fit, size, and color) will be before cementation.

(Initials _____)

○ 6. Dentures, complete, or partial

I realize that full or partial dentures are artificial, consutrcted of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including loosness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try -in visit. 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.

(Initials _____)

○ 7. Endodontic treatment

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment. (apicoectomy)

(Initials _____)

○ 8. Periodontal loss (tissue & bone)

I understand that I have a serious condition, causing gum and bone infection 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 undertaking any dental procedures may have a future adverse effect on my periodontal condition.

(Initials _____)

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully 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 have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient: _____ Date: _____
Signature of Parent/Guardian if patient is a minor: _____ Date: _____

DATE	DESCRIPTION OF WORK