**Sedation and Implant Dentistry of Tehachapi**

**PATIENT INFORMATION**

Name_____ Date_____
First Middle Last

Address_____City_____ State_____ Zip_____

Home Phone_____ Mobile #_____ Soc. Security #_____ Date of Birth_____

Email_____ Check Box: Minor ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐

Employer_____ Work Phone_____

Business Address_____City_____State_____ Zip_____

If College Student, Name of School _____ City _____State_____

Patient / Parent's Employer _____ Work Phone_____

Business Address_____City_____State_____ Zip_____

Spouse or Parent's Name _____ Employer_____ Work phone_____

Person to Contact in Case of an Emergency_____ Phone_____

Relationship_____Whom may we thank for referring you? _____

**RESPONSIBLE PARTY**

Name of Person Responsible for Account_____Relationship to Patient_____

Address_____Home Phone_____

Driver's License #_____State _____Date of Birth_____ Social Security#_____

Employer _____Work phone_____

Is this person currently a patient in our office? Yes ☐ No ☐

**INSURANCE INFORMATION**

Name of insured _____ Relationship to Patient_____

Date of Birth_____Soc. Security #_____Date Employed_____

Name of Employer_____Union or Local #_____Work Phone_____

Employer Address_____City_____ ____State_____Zip_____

Insurance Co. _____ Tel. # _____ Grp. #_____Policy/I.D.# _____

How much is your deductible? _____ How much have you used?_____ Max Annual Benefit_____

Do you have any additional dental insurance? Yes ☐ No ☐ If yes, complete the following:

Name of Insured_____Soc. Security #_____ Date Employed_____

Name of Employer_____ Work Phone_____ Union or Local #_____

Employer Address_____ City_____ State_____ Zip_____

Insurance Co. _____ Tel.# _____ Group#_____ Policy/I.D. # _____

Ins. Co. Address_____ City_____ State_____ Zip_____

How much is your deductible? _____ How much have you used? _____ Max Annual Benefit_____

**AUTHORIZATION AND RELEASE**

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

_____ _____
Print Patient Name Date

_____ _____
Signature of Patient (or parent, if minor) Date

**Sedation and Implant Dentistry of Tehachapi**

**DENTAL HISTORY**

**PATIENT'S NAME**_____ **DATE OF BIRTH** _____

Reason For This Visit _____

When Was Your Last Dental Visit?_____What Was Done Then? _____

How Often Did You Visit The Dentist Before Then? _____

Previous Dentist (Name And Location) _____

Have You Had A Complete Series Of Dental Films (X-Rays) Taken- When & Where? _____

How Often Do You Brush Your Teeth? _____ How Often Do You Floss Your Teeth? _____

Is Your Drinking Water Fluoridated? YES ____ NO____

| | YES | NO |
|---|---|---|
| Do your gums bleed while brushing or flossing? | ☐ | ☐ |
| Are your teeth sensitive to hot or cold liquids/foods? | ☐ | ☐ |
| Are your teeth sensitive to sweet or sour liquids/foods? | ☐ | ☐ |
| Do you feel pain to any of your teeth? | ☐ | ☐ |
| Do you have any sores or lumps in or near your mouth? | ☐ | ☐ |
| Have you had any head, neck, or jaw injuries? | ☐ | ☐ |
| Have you experienced any of the following problems: | | |
| Clicking in your jaw | ☐ | ☐ |
| Pain (joint, ear, side of face) | ☐ | ☐ |
| Difficulty in opening or closing your jaw | ☐ | ☐ |
| Difficulty in chewing | ☐ | ☐ |
| Do you have frequent headaches? | ☐ | ☐ |
| Do you clench or grind your teeth? | ☐ | ☐ |

| | YES | NO |
|---|---|---|
| Do you bite your lips or cheeks frequently? | ☐ | ☐ |
| Have you noticed any loosening of your teeth? | ☐ | ☐ |
| Does food tend to become caught between your teeth? | ☐ | ☐ |
| Have you ever had periodontal treatment (gums)? | ☐ | ☐ |
| Have you ever worn a bite plate or other appliance? | ☐ | ☐ |
| Have you had any difficult extractions in the past? | ☐ | ☐ |
| Have you ever had any prolonged bleeding following extractions? | ☐ | ☐ |
| Do you wear dentures or partials? | ☐ | ☐ |
| If yes, give the date they were placed | | |
| Have you ever received oral hygiene instructions regarding the care of your teeth? | ☐ | ☐ |

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMIE, WHAT WOULD YOU CHANGE?

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_____ _____

PRINT PATIENT NAME (OR PARENT/GUARDIAN IF MINOR) DATE

_____ _____

SIGNATURE OF PATIENT (OR PARENT/GUARDIAN IF MINOR) DATE

_____ _____

DOCTOR'S SIGNATURE DATE

NOTES:_____

**Sedation and Implant Dentistry of Tehachapi**

**MEDICAL HISTORY**

Patient Name_____ Date of Birth_____

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 that you will be receiving. Thank you for answering the following questions.

Primary Physician's Name_____ Phone_____

Address_____ Date of Last Exam_____

Please list all medication (including non-prescription) you are taking?_____

_____

Have you been hospitalized for any operation or serious illness? Yes ____ No____ Please explain_____

_____

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Are you in good health? | | | Have you taken Fosamax or a Bisphosphonate Derivative? | | |
| Has your health changed in the past year? | | | Do you use tobacco? | | |
| Are you under care of a physician? | | | Do you or have you used controlled substances? | | |
| Have you had a recent weight loss? | | | Are you wearing contact lenses? | | |
| Have you ever taken Fen-Phen or Reedux? | | | Do you have any disease, condition or problem not listed above that you think I should know about? Explain_____ _____ | | |
| Have you had any abnormal bleeding? | | | | | |
| Do you bruise easily? | | | **WOMEN ONLY:** | | |
| Have you ever required a blood transfusion? | | | Are you pregnant or think you may be pregnant? | | |
| Are you nursing? | | | Are you nursing? | | |
| Are you taking birth control? | | | Are you taking birth control? | | |

| **Are You Allergic To Or Have You Had Reactions To:** | YES | NO | **Are You Allergic To Or Have You Had Reactions To:** | YES | NO |
|---|---|---|---|---|---|
| Local anesthetics like vocaine | | | Hives Of Skin Rash | | |
| Penicillin or other antibiotics | | | Fainting Or Dizzy Spells | | |
| SULFA drugs | | | Diabetes | | |
| Barbiturates, sedatives or sleeping pills | | | Anemia | | |
| Aspirin | | | Epilepsy Or Seizures | | |
| Iodine | | | AIDS Or HIV Infection | | |
| Any metals (e.g., nickel mercury) | | | Thyroid Problems | | |
| Latex Rubber | | | Allergies | | |
| Other: Please List_____ | | | Arthritis Or Rheumatism | | |
| **Do You Have / Have You Ever Had The Following?** | **YES** | **NO** | Joint Replacement Or Implant | | |
| Rheumatic Heart Disease / Rheumatic-Fever | | | Stomach Ulcer | | |
| Scarlet Fever | | | Kidney Trouble | | |
| Heart Defect Or Heart Murmur | | | Tuberculosis | | |
| Heart Trouble/Heart Attack/Angina Anemia | | | Persistent Cough | | |
| Chest Pain | | | Chemotherapy (Cancer, Leukemia) | | |
| Shortness Of Breath | | | Sexually Transmitted Disease | | |
| Pacemaker | | | Antral Valve Prolapse | | |
| Heart Surgery | | | Glaucoma | | |
| Congenital Heart Problem | | | Cortisone Treatment | | |
| High/Low Blood Pressure | | | Nervousness | | |
| Swelling Of Feet, Ankles, Hands | | | Cold Sores/Fever Blisters | | |
| Hepatitis, Jaundice Or Liver Disease | | | Tonsillitis | | |
| Stroke | | | Hypoglycemia | | |
| Sinus Trouble | | | Tumors | | |
| Lung Or Breathing Problems | | | Eating Disorders | | |
| Cough That Produces Blood | | | Mental Health Care | | |
| Asthma Or Hay Fever | | | Back Problems | | |

**CERTIFICATION**
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_____ _____
Print Patient Name Date

_____ _____
Signature of Patient (Parent, if Minor) Date

**Sedation and Implant Dentistry of Tehachapi**
20370 Valley Blvd.
Tehachapi, CA 93561

## INFORMED CONSENT FORM

**Patient Name:** _____ **Date:** _____

**1. GENERAL**
Antibiotics, analgesia, local anesthetic and other medications can cause allergic reactions causing redness and swelling of tissues, numbness of indefinite duration, pain, vomiting, and/or anaphylactic shock. Taking certain antibiotics can interfere with the effectiveness of oral contraceptives. Administration of local anesthetic or exertion of the jaw during the dental procedure can cause pain and/or restrictive movement in the temporomandibular joint and surrounding muscle. I have read and understand the treatments and terms listed above. Initial/Date _____/_____

**2. ANESTHESIA**
The administration and monitoring of general anesthesia may vary depending on the type of procedure, type of practitioner, the age and health of the patient and the setting in which anesthesia is provided. Risks may vary with each situation. You are encouraged to explore all options available to you and/or your child and consult with a dentist or pediatrician.I have read and understand the treatment and terms listed Initial/Date _____/_____

**3. CHANGES IN TREATMENT PLAN**
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; for example root canal therapy following routine restorative procedures or crowns. Therefore, fees can only be estimated and are subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of the treatment. I have read and understand the treatment and terms listed above and give permission to the Dentist to make any changes necessary. Initial/Date _____/_____

**4. CROWNS, BRIDGES AND CAPS**
Conditions that require crowns to be made may also require a root canal treatment for their resolution. This sometimes becomes apparent after the crown is placed. I may be wearing temporary crowns or permanent crowns with temporary cement which may come off easily and must be careful to ensure they are kept on until the permanent crowns are permanently cemented. It is my responsibility to return for permanent cementation within 45 days of the tooth preparation. Excessive delays may allow tooth movement which may necessitate a remake of the crown, bridge or cap. There will be additional charges for remakes due to my delaying permanent cementation. Sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. The final opportunity to make changes in my crown, bridge, or cap (shape, size, fit and color) will be before permanent cementation. I have read and understand the treatment and terms listed above. Initial/Date _____/_____

**5. DENTURES**
Wearing dentures can be difficult. Sores spots, altered speech and difficulty eating are common problems. Immediate denture placement after extractions may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later and is not included in the denture fee. It is my responsibility to return for delivery and failure to do so may result in poorly fitting dentures. If a remake is required due to my delay of more than 30 days, there will be additional charges. I have read and understand the treatment and terms listed. Initial/Date _____/_____

**6. ENDODONTIC TREATMENT (ROOT CANAL)**
Root canal therapy usually takes several appointments for completion. I must return for all appointments to complete my treatment. There is no guarantee that root canal treatment will save the tooth. Complications can occur and occasionally root canal filling material may extend through the tooth, which does not necessarily affect the success of the treatment. Endodontic files and reamers are very fine instruments and stresses vented in their manufacture can cause them to separate during use. Sometimes additional surgical procedures may be necessary following a root canal treatment (apicoectomy). As a rule, a crown will be necessary in order to prevent the tooth from fracturing. The tooth may be lost in spite of all effort to save it. I have read and understand the treatment and terms listed above. Initial/Date _____/_____

**7. FILLINGS**
Care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. A more serious extensive filling (than originally diagnosed) may be required due to additional decay. Significant sensitivity is a common after-effect on newly places fillings. I have read and understand the treatment and terms listed above. Initial/Date _____/_____

**8. PERIODONTAL LOSS (TISSUE AND BONE)**
Periodontal disease is a serious condition, causing gum and bone inflammation or loss that can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery and/or extractions. Undertaking any dental procedures may have a future adverse effect on my periodontal condition by complicating oral hygiene procedures. I have read and understand the treatments and terms listed. Initial/Date _____/_____

**9. RADIOGRAPHS**
Dentist requires the use of radiographs to properly diagnose my dental treatment. Radiographs will be used as a record of my care and may be used with my given name and sent to my insurance carrier, other Dentists, and for educational purposes, demonstration and other lawful purposes. I have read and understand the treatment and terms listed. Initial/Date _____/_____

**10. PHOTOS**
The Dentist and staff may take photographs, intra-oral slides, and/or videos of my face, jaws and teeth. The photographs, intraoral slides, and/or videos will be used as a record of my care, and may be used without my given name or with a fictitious name for educational purposes, in demonstrations, professional publications and any other lawful purpose. I release and forever discharge Sedation and Implant Dentistry Irvine from any claim, demands or liability on account of such use or for the quality of the reproduction of the image. I have read and understand the treatments and terms listed. Initial/Date _____/_____

**11. REMOVAL OF TEETH**
Alternatives to removal have been explained to me (root canal, crowns, periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth _____ and any other necessary for reasons in paragraph #3. Removing the teeth does not always remove all of the infection, if present, and it may be necessary for further treatment. The risks involved in having teeth removed can include pain, swelling, spread of infection, bone fracture, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissues (paresthesia) that can last for an indefinite period of time. I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility. I have read and understand the treatment and terms listed above.
Initial/Date _____/_____

_____
Print Name

_____ _____
Signature (Patient, Parent or Legal Guardian) Date

## Sedation and Implant Dentistry of Tehachapi

## FINANCIAL POLICY

We are committed to providing you with the best possible dental care. Your clear understanding of our Financial Policy is important to our professional relationship. We are pleased to discuss professional fees with you at any time. Please ask if you have any questions.

All Patients must complete our "Patient Information Form" before seeing the doctor.

For all emergency (same day) appointments, payment is due in full on the day of service.

We accept cash, Visa, MasterCard, Discover, and American Express.

For your future appointments, payments are due in advance of your treatment to reserve the doctor's time. For minor patients, his/her parent(s) or guardian(s) are responsible for any account balance.

For patients with insurance, we are not contracted with any insurance company. We will help you receive the maximum benefits by assisting in submitting insurance claims. Payments will be directly sent to the patient. We cannot guarantee reimbursement from your insurance company.

Insurance is a contract between you and your insurance company. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, pre-authorizations, etc., other than to supply factual information as necessary. You are responsible for the timely payment of your account.

If for any reason you must cancel or reschedule an appointment, you MUST notify the office two days (48 HRS) in advance. Failure to do so will result in charges for the time you reserved. These charges will be 25% (minimum $50) of the procedure amount agreed upon.

**I acknowledge and agree to pay reasonable collection fees attorney fees and court cost incurred in collection of my overdue account. I have read, understand and agree with the above Financial Policy.**

_____ _____

Name Date

_____

Signature / Legal Guardian (if a minor)

**Sedation and Implant Dentistry of Tehachapi**

## SLEEP DISORDER SYMPTOMS ASSESSMENT

Name:_____ Date _____

Date of Birth: (M/D/Y) _____/_____/_____ Gender: M____ F____ Height: _____ Weight: _____

| **Please Check Any Of The Following You May Have:** | | | |
|---|---|---|---|
| ☐ High Blood Pressure | ☐ Heart Disease | ☐ Stroke | ☐ Insomnia |
| ☐ Diabetes | ☐ Depression | ☐ Overweight | ☐ Frequent Urination at Night (Nocturia) |

| **SNORING** | **YES** | **NO** | **DON'T KNOW** | **SCORE** |
|---|---|---|---|---|
| 1. Do you snore often (3 or more nights a week)? | | | | ___ Yes = 1 |
| 2. Is your snoring loud enough to be heard through a closed door or annoy other people? | | | | ___ Yes = 1 |
| 3. Have you noticed or been told that during sleep, you frequently stop breathing or gasp for air? | | | | ___ Yes = 2 |
| (sum of all numbers checked above) **Total Score** | | | | |

| **EPWORTH SLEEPINESS SCALE** | **Never Would Doze Off** | **Slight Chance Of Dozing** | **Moderate Chance Of Dozing** | **High Chance Of Dozing** |
|---|---|---|---|---|
| 1. Do you get sleepy, or doze off, while sitting and reading? | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |
| 2. Do you get sleepy, or doze off, while watching TV? | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |
| 3. While sitting or inactive in a public place (meeting, theater)? | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |
| 4. As a passenger in a car for an hour without a break? | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |
| 5. Lying down to rest in the afternoon? | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |
| 6. Sitting and talking to someone? | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |
| 7. Sitting quietly after lunch without alcohol? | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |
| 8. In a car, while stopped for a few minutes at a traffic light? | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |
| (sum of all numbers checked above) | | | | |
| **Total Score** | | | | |

| **CPAP:** |
|---|
| Are you currently using CPAP? ☐ YES ☐ NO ☐ If yes, for how long? _____ |

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_____ _____
Print Patient Name Date

_____ _____
Signature of Patient (Parent, if Minor) Date

Sedation and Implant Dentistry of Tehachapi

# DENTAL MATERIALS FACT SHEET

I, _____, acknowledge that I have
Print Patient Name

received a copy of the Dental Materials Fact Sheet Adopted by the board on October 17, 2001.

_____ _____
Patient Name Date

_____
Patient Signature

As required by Chapter 801, Statues 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 fact sheet is intended to encourage discussion between the patient and dentist regarding the selection of dental materials best 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 is sparse, we have indicated our best perceptions based upon information that pre-dated 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 ancillary materials used in the procedure, and the patient's cooperation during the procedure. Following restoration of teeth, the longevity of the restoration will be strongly influenced by the patient's compliance with dental hygiene and home care; their diet and chewing habits; their regular office visits to allow maintenance of the materials, detection of decay and periodontal disease. It is the goal of the Sedation and Implant Dentistry Irvine to provide the best long-term treatment for our patients using the best materials available.

_____ _____
Patient Name Date

_____
Signature / Legal Guardian (if a minor)