WARNER VILLAGE DENTAL

21516 Victory Blvd
Woodland Hills, CA 91367
(818) 884-2700

*Please give your **DENTAL INSURANCE** Information or card to the receptionist*

Welcome to our office! Chart #_____

THANK YOU FOR COMPLETEING THE FOLLOWING CONFIDENTIAL INFORMATION.

Name(Mr. Mrs. Ms. Dr. Rev.)_____ Birth date_____

Home Address_____

City_____ St._____ Zip_____ Social Security Number_____

Home Phone ( )_____ Work # ( )_____ Ext _____ Cell # ( )_____

Please circle: Male Female Married Single Divorced Widowed *Email Address_____

How would you like us to confirm appointments? Home #____ Work____ Email____ Cell_____(Carrier_____)

Whom may we thank for referring you? _____
Or how did you hear about us? (Circle) Yellow Pages Relative Co-Worker Internet Walk-In Other_____

Name & number of Emergency contact _____

EMPLOYER & FINANCIAL

Person responsible for account: _____ Birth date_____

Insurance Name_____ Subscriber's Name _____ _____

Employer's Name _____May we call you at work? ____

DENTAL HEALTH & APPEARANCE

What is the *primary* concern you would like us to address first?_____
_____

Approximate date of last dental visit**:**_____
Have you ever had any serious problem associated with previous dental treatment? Yes No ☐
If so, please explain:_____
What, if anything, has happened in previous experiences at the dentist that was reason not to return?_____
_____

Do you have any of the following? (*circle*)

Tenderness while chewing	Head, neck or face pain	Food catches between teeth	Pain when biting
Sensitivity to sweets	Clicking or popping of jaw	Tender or bleeding gums	Swellings or sores in mouth
Sensitivity to hot or cold	Clinch or grind teeth	Missing teeth	Snore regularly

If you have missing teeth, have you had them replaced?_____
If you have had missing teeth replaced, are you happy with the results?_____

Do you feel (or have you ever been told) that you don't have fresh breath?_____

How often do you brush your teeth?_____How often do you floss (routinely)?_____

COSMETIC EVALUATION

Are you happy with your smile?_____
Please rate your smile from 1 to 10 (1= I dislike my smile, 10= love my smile)_____
If you could, what, if anything, would you change about your smile?_____
_____

If you would like an improved smile please check off all that apply:

☐ Lighten all front teeth showing	☐ Rebuild fractures(s)	☐ Straighten rotation	☐ Eliminate dark or stained fillings
☐ Lighten single tooth	☐ Lengthen	☐ Straighten angulation	☐ Reduce gum showing in smile
☐ Close spaces between teeth	☐ Shorten	☐ Eliminate crowding	☐ Repair uneven edges

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
*** You May Refuse to Sign This Acknowledgement***

I, _____,
*(PLEASE PRINT)

am aware this office follows HIPPA regulations and that I may request a copy of the Notice of Privacy Practices

_____
*Signature

_____
*Date

PATIENT ACKNOWLEDMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET
I acknowledge that I have reviewed a copy of the Dental Materials Fact Sheet dated May 2004.

*Patient Signature_____ Date_____

Authorization and Consent

1. To the best of my knowledge, all of the preceding answers are true, complete, and correct. I hereby authorize Warner Village Dental to take necessary radiographs (X-rays), study models, photographs, and any other diagnostic aids deemed appropriate to make a thorough diagnostic of the patient's dental needs. I also authorize them to perform treatment, therapy or medication deemed necessary by the doctor and agreed upon by the patient. I understand that the use of anesthetic agents or nitrous oxide gas embodies a certain risk
2. I also understand that responsibility for payment for dental services provided for myself and my dependents is mine and is due and payable at the time services are rendered. There may be addition charges for late payments, broken appointments, returned checks and collection cost.
3. I understand that it is necessary to give **24 hours** prior notice to change or cancel any dental appointment in order to avoid a $25 fee for a broken appointment. For appointments of 2 or more hours please give a 48 hours notice. **Acknowledged Initials**: _____
4 . Insurance. I understand that any insurance estimate given to me by Warner Village Dental are estimates and cannot be a guarantee of payment by my insurance company. I understand that I am responsible for the entire balance. I give Warner Village Dental permission to give my insurance company any information that is necessary to process my insurance claim.

Patient or Responsible Party
Signature:_____Date:_____

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HEALTH HISTORY

Patient's Name _____ Date of Birth _____ Today's Date _____

Please Answer all questions by circling Yes (Y) or No (N) ***All responses are kept confidential***

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? ..... Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe: ..... Y N

   _____

   _____
6. Height _____ Weight _____
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? ..... Y N
   - B. Congenital Heart Disease? ..... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) ..... Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ..... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness ..... Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ..... Y N
   - G. Liver Disease (Jaundice, Hepatitis)? ..... Y N
   - H. Kidney Disease? ..... Y N
   - I. Diabetes? ..... Y N
   - J. Thyroid Disease (Goiter)? ..... Y N
   - K. Arthritis? ..... Y N
   - L. Stomach Ulcers or Colitis? ..... Y N
   - M. Glaucoma? ..... Y N
   - N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ..... Y N
   - O. Radiation (X-ray) treatment for Cancer? ..... Y N
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Y N
   - Q. Sinus or Nasal problems? ..... Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system? ..... Y N
8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics? ..... Y N
   - B. Anticoagulants (Blood Thinners)? ..... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N
   - D. High Blood Pressure medications? ..... Y N
   - E. Steroids (Cortisone, etc.)? ..... Y N
   - F. Tranquilizers ..... Y N
   - G. Insulin or Oral Anti-Diabetic drugs? ..... Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
   - I. Are you taking or *have you ever taken* Bisphosphonates (Fosamax or Actonel for osteoporosis, or chemotherapy for multiple myeloma, etc.) ? ..... Y N
   - J. Please list any and all medications taken, including prescription medications, over-the-counter mediations, herbal or holistic remedies, vitamins or minerals: _____

     _____

     _____
9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, etc.)? ..... Y N
   - B. Penicillin or other antibiotics? ..... Y N
   - C. Sedatives, Barbiturates? ..... Y N
   - D. Aspirin or Ibuprofen? ..... Y N
   - E. Codeine or other pain killers? ..... Y N
   - F. Latex or Rubber Products? ..... Y N
   - G. Other allergies or reactions? Please, list ..... Y N

     _____

     _____
10. Do you smoke or chew Tobacco? ..... Y N
    How much per day? _____
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? ..... Y N
12. Have you had any serious problems associated with any previous dental treatment? ..... Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia? ..... Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y N
15. Do you wish to talk to the doctor privately about anything? ..... Y N
16. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **is there any chance** you might be Pregnant? ..... Y N
    - B. Are you nursing? ..... Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible and that I will have the opportunity to discuss my Health History with my doctor during this appointment.

_____ _____ _____
Date | Signature of Person Completing Health History | Doctor's Initials

Medical Update: I have read my Health History dated _____ and confirm that it adequately states past and present conditions.

Date	Exceptions or changes	Patient's Signature	Doctor's Initials