Welcome to OC Lakes Dental!
2 Osborn Street, Suite 150
Irvine, CA 92604

Today's Date: _____/_____/_____

Personal Information

Name: _____ Date of Birth: _____/ _____/ _____
Last First

Sex: _____ ☐Single ☐Married, Name of Spouse _____ Legal Guardian: _____

Address: _____ Apt #: _____ City: _____ Zip: _____

Phone: (_____)_____-_____ Cell: (_____)_____-_____ Email: _____

Social Security #: _____ Occupation: _____ Employer: _____

How did you hear about us? _____

Is there anything that we can do to make your visit more comfortable? _____

Insurance Information (Primary)

Insurance Company: _____ Employer: _____

Insurance Address: _____ Phone: (_____)_____-_____

Group Name: _____ Group Number: _____

Subscriber/Member ID: _____ Relationship: ☐Self ☐Spouse ☐Dependent

Insurance Information (Secondary)

Insurance Company: _____ Employer: _____

Insurance Address: _____ Phone: (_____)_____-_____

Group Name: _____ Group Number: _____

Subscriber/Member ID: _____ Relationship: ☐Self ☐Spouse ☐Dependent

Financial Agreement

- For my convenience, I hereby authorize payment directly to the dentist of the group insurance benefits otherwise payable to me this office may release my information to my insurance.
- Every effort will be made to help me with my insurance. I understand that I am financially responsible for any charges not covered or denied by my insurance.
- I understand that treatment plans may change and I am responsible for all work actually completed.
- I certify that all information provided is accurate, true, and to the best of my knowledge.

Signature of responsible party: _____ Date: _____/ _____/ _____

Dental History

Please check any of the following problems that apply to you:

- ☐ Sensitivity (hot, cold, or sweet?)
- ☐ Dry mouth
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, ear aches, neck pain
- ☐ Mouth ulcers or cold sores
- ☐ Jaw joint pain (popping)
- ☐ Broken tooth or fillings
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifted teeth
- ☐ Bad breath or bad taste in your mouth

Do you have or have you had any of the following?

- ☐ Dentures ☐ Partial dentures
- ☐ Braces
- ☐ Gum treatments
- ☐ Required to take antibiotics prior to dental treatment?

Please share the following dates:

Your last cleaning: _____/_____

Your last oral cancer screening: _____/_____

Your last complete set of dental x-rays: _____/_____

If you could change your smile, you would:

- ☐ Make my teeth whiter
- ☐ Make my teeth straighter
- ☐ Close spaces
- ☐ Replace metal fillings with tooth colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

Previous Dentist: _____

City: _____ State: _____

Phone number: (_____)_____-_____

On a scale of 1-10, 10 being the highest rating:

a) How important is your dental health to you? _____

b) Where would you rate your current dental health? _____

c) Dental anxiety or fear? _____

Medical History

- ☐ Anemia
- ☐ Excessive Bleeding (INR > 3)
- ☐ Blood Disease
- ☐ Heart problems or surgery
- ☐ History of infective endocarditis
- ☐ Artificial heart valve, repaired heart defect
- ☐ Pacemaker or implantable defibrillator
- ☐ Stroke (taking blood thinners)
- ☐ Rheumatic or scarlet fever
- ☐ High or Low blood pressure
- ☐ High Cholesterol
- ☐ Allergies (Seasonal)
- ☐ Asthma
- ☐ Emphysema, Shortness of breath
- ☐ COPD – Breathing problems
- ☐ Snoring or sinus problems
- ☐ Sleep Apnea
- ☐ Glaucoma
- ☐ Tuberculosis
- ☐ Diabetes (HbA1c = _____)
- ☐ Digestive disorders
- ☐ Stomach or duodenal ulcer
- ☐ Acid/gastric reflux
- ☐ Celiac disease
- ☐ Crohn's disease (celiac disease, gastric reflux)
- ☐ Caner (abnormal growth)
- ☐ Radio or Chemotherapy
- ☐ Hepatitis (A,B,C)
- ☐ HIV/AIDS
- ☐ Arthritis/Rheumatoid Arthritis/Lupus
- ☐ Osteoporosis / Osteopenia
  - ☐ Bisphosphonates (IV or Oral)
  - ☐ Fosamax
  - ☐ Aredia
  - ☐ Fen-Phen
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Thyroid disease
- ☐ Dizziness/Fainting
- ☐ Artificial joints (Date: _____)
- ☐ Herpes (Cold sores)
- ☐ STI/STD
- ☐ Neurological Disorders (ADHD)
- ☐ Epilepsy or Seizures
- ☐ Psychiatric Care
- ☐ Anti-depressants
- ☐ Alcohol / Recreational drugs
- ☐ Drug addiction
- ☐ Smoking (all forms)
- ☐ FEMALE – Birth control
- ☐ FEMALE – Pregnant (1st / 2nd / 3rd)
- ☐ MALE – Prostate disorder

Are you allergic to any of the following?

- ☐ Aspirin / Ibuprofen / NSAIDS
- ☐ Acetaminophen
- ☐ Penicillin / Erythromycin
- ☐ Sulfa
- ☐ Metals (gold / silver / copper / nickel)
- ☐ Latex
- ☐ Other: _____

Are you taking any medications?	**Any past hospitalizations?** ☐Y ☐N
Drug: _____ Purpose: _____ Drug: _____ Purpose: _____ Drug: _____ Purpose: _____ Drug: _____ Purpose: _____ Drug: _____ Purpose: _____	Date(s): _____ Reason: _____ _____ Reason: _____ **Any unlisted medical conditions?** _____ _____ Is there any issue or condition which you would like to discuss with the dentist in private? ☐Y ☐N

The practice of dentistry involved treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.
I hereby authorize the dentist to contact my physician.

Signature of Patient/Guardian: _____ Date: _____/ _____/ _____

Name of Physician: _____ Phone: (_____)_____-_____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medications. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in completion of this form.

Signature of Patient/Guardian: _____ Date: _____/ _____/ _____

Signature of Dentist: _____ Date: _____/ _____/ _____

MEDICAL UPDATES:

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	CHANGES TO HEALTH HISTORY	PATIENT SIGNATURE	DENTIST

Informed Consent

1. **Examinations and X-rays:** I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. (Initials:)

2. **Drugs, Medications, and Sedation:** I have been informed and understand that antibiotics and other medications can cause allergic reaction causing redness and swelling of tissues, pain, itching, vomiting, and or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given to me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives. (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 routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary. (Initials:)

4. **Temporomandibular Joint Dysfunction (TMD):** I understand that symptoms of clicking, locking and pain can intensify or develop in the joint of the lower jaw subsequent to routine dental treatment wherein the mouth is held open. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility. (Initials:)

5. **Fillings:** I understand that care must be exercised in chewing on filling during the first 24 hours to avoid breakage. I understand that transient sensitivity is a common after effect of newly placed filling. (Initials:)

6. **Removal of Teeth:** Alternatives to removal have been explained 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 may be necessary to have further treatment. I understand the risk 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 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:)

7. **Crowns, Brides, Caps, Veneers and Bonding:** 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 that the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation. It has been explained to me that, in very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may effect tooth surfaces and may require modification of daily cleaning procedures. (Initials:)

8. **Dentures Complete or Partial:** I realize that full or partial dentures are artificial, constructed of plastic, metal, and or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (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:)

9. **Endodontic Treatment (Root Canal):** I realize there is no guarantee that root canal treatment will save may 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:)

10. **Periodontal Treatment (Scaling and Root Planing) / Prophylaxis:** I understand that I have a serious condition causing gum inflammation and or bone loss, and that it can lead to loss of my teeth. Alternative treatment plan have been explained to me, including non-surgical cleaning, gum surgery, and or extraction of teeth. I understand the success of any treatment depends in part on my effort to brush and floss daily, receive regular cleaning as directed, avoid tobacco products and follow other recommendations. (Initials:)

I understand that dentistry is not an exact science and therefore reputable Practitioners cannot properly guarantee results. I acknowledge that no guarantee has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I understand that the Dental Materials Fact Sheet is available upon request.