Please use Adobe Acrobat on your computer to complete the following forms and either email them back to us or print them to bring with you to your next appointment.

# PATIENT INFORMATION

| IF THIS APPOINTMENT IS FOR YOU | | | IF THIS APPOINTMENT IS FOR YOUR CHILD | | |
|---|---|---|---|---|---|
| NAME | | | NAME | | |
| SPOUSE | | | ADDRESS | | |
| ADDRESS | | | CITY STATE ZIP | | |
| CITY STATE ZIP | | | HOME PHONE NO. | | |
| HOME PHONE NO. | | | BIRTHDATE | AGE | MALE / FEMALE ☐ ☐ |
| CELL PHONE NO. | | MARITAL STATUS | SCHOOL | | |
| BIRTHDATE | AGE | MALE / FEMALE ☐ ☐ | . | | |
| DRIVER LICENSE | . | | IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS FILL IN THE LEFT SECTION ALSO | | |

## GETTING TO KNOW YOU

| | |
|---|---|
| WHOM CAN WE THANK FOR THE REFERRAL? | PERSON TO CONTACT IN AN EMERGENCY NOT LIVING WITH YOU |
| YOUR EMAIL ADDRESS | PHONE NUMBER |
| SHOULD WE CONFIRM YOUR APPOINTMENT BY ☐ EMAIL ☐ TEXT ☐ PHONE | ADDRESS |
| | CITY STATE ZIP |

## ACCOUNT INFORMATION

**PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT**

| | | |
|---|---|---|
| NAME | | |
| RELATIONSHIP TO PATIENT | | |
| ADDRESS | | |
| CITY STATE ZIP | | |
| PHONE NUMBER | | |

**YOU**

| | | |
|---|---|---|
| NAME | | |
| OCCUPATION | | |
| EMPLOYER | | |
| BUSINESS ADDRESS CITY | | |
| BUSINESS PHONE NO. EXT. | | |

**YOUR SPOUSE**

| | | |
|---|---|---|
| NAME | | |
| OCCUPATION | | |
| EMPLOYER | | |
| BUSINESS ADDRESS CITY | | |
| BUSINESS PHONE NO. EXT. | | |

## DENTAL INSURANCE

**PRIMARY CARRIER**

| | | |
|---|---|---|
| POLICYHOLDER'S FULL NAME | | |
| INSURANCE COMPANY | | |
| GROUP NUMBER | | |
| INSURANCE ID | EMPLOYEE NO. | |
| DATE OF BIRTH | DATE EMPLOYED | |

**SECONDARY CARRIER**

| | | |
|---|---|---|
| POLICYHOLDER'S FULL NAME | | |
| INSURANCE COMPANY | | |
| GROUP NUMBER | | |
| INSURANCE ID | EMPLOYEE NO. | |
| DATE OF BIRTH | DATE EMPLOYED | |

**ADDITIONAL INSURANCE INFORMATION**

FOR OFFICE USE ONLY

| PATIENT NAME | DENTAL HISTORY |
|---|---|
| PATIENT ACCOUNT NUMBER | DENTAL ALERT |

**Welcome! So that we may provide you with the best possible care, please take a moment to complete the following forms making sure that all questions have been answered to the best of your knowledge. All information will be kept confidential.**

What is the reason for your visit today? _____

_____

Date of Last Dental Visit _____ Last Cleaning? _____ Last Complete Set of X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____ Address _____

Telephone Number _____ _____

How often do you have dental exams or cleanings? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Braun, Sonicare, toothpicks, proxabrush, etc.)

_____

Do you have any dental problems? If yes, please describe _____

_____

| **Are any of your teeth sensitive to:** | Yes | No |
|---|---|---|
| Hot or cold | ☐ | ☐ |
| Sweets | ☐ | ☐ |
| Biting or Chewing | ☐ | ☐ |

| **Have you noticed:** | Yes | No |
|---|---|---|
| Mouth odor or bad taste? | ☐ | ☐ |
| Difficulty in chewing on either side of your mouth? | ☐ | ☐ |
| Gums that bleed or hurt? | ☐ | ☐ |
| Any loose teeth? | ☐ | ☐ |
| Areas where food tends to become caught in between your teeth? | ☐ | ☐ |

If yes, where? _____

| **Do you:** | Yes | No |
|---|---|---|
| Clench or grind your teeth? | ☐ | ☐ |
| Smoke/chew tobacco? | ☐ | ☐ |
| Hold foreign objects with your teeth (pencils, pipes, pins, nails, fingernails, etc.)? | ☐ | ☐ |
| Use currently or have you ever used a hard or medium toothbrush? | ☐ | ☐ |
| Feel anxious about having dental treatment? | ☐ | ☐ |
| Have memories from an upsetting dental experience? If yes, please describe: | ☐ | ☐ |

_____

_____

_____

| **Have you ever experienced:** | Yes | No |
|---|---|---|
| Clicking or popping of your jaw? | ☐ | ☐ |
| TMJ, jaw muscle or facial pain? | ☐ | ☐ |
| Does your jaw get tired during dental visits requiring that you take a break? | ☐ | ☐ |

| **Have you ever had:** | Yes | No |
|---|---|---|
| Orthodontic treatment? | ☐ | ☐ |
| Periodontal Treatment? | ☐ | ☐ |
| A Sleep Study? | ☐ | ☐ |
| A diagnosis of sleep apnea? | ☐ | ☐ |
| To use a CPAP machine? | ☐ | ☐ |
| A nightguard or other removable appliance? | ☐ | ☐ |
| A serious injury to your head or mouth? | ☐ | ☐ |

If yes, please describe _____

| **Smile Evaluation:** | Yes | No |
|---|---|---|
| Are you satisfied with the appearance of your teeth? | ☐ | ☐ |
| Would you like whiter teeth? | ☐ | ☐ |
| Would you like straighter teeth? | ☐ | ☐ |
| Are there spaces that you would like closed? | ☐ | ☐ |
| Do you have chipped, protruding, or hidden teeth? | ☐ | ☐ |
| Do you have old fillings or old dental work you don't like looking at? | ☐ | ☐ |
| Is there anything else you would like to change in your smile? If yes, please explain | ☐ | ☐ |

_____

_____

_____

| **Is there anything else about your dental history or preferences that you would like us to know?** | Yes | No |
|---|---|---|
| | ☐ | ☐ |

If yes, please describe _____

_____

_____

| PATIENT NAME | |
|---|---|
| PATIENT ACCOUNT NUMBER | MEDICAL ALERT |

# MEDICAL HISTORY

Place an "x" indicating yes or no for each of the questions below

| | Yes | No |
|---|---|---|
| 1 Have you been under the care of a medical doctor during the last two years? | ☐ | ☐ |
| If yes, for what? _____ | | |
| Physician Name _____ | | |
| Address _____ | | |
| 2 Are you currently taking or have taken any medications or drugs in the past two years? If yes, please list them to the right or provide a medication list on a separate paper. | ☐ | ☐ |
| 3 Have you ever taken IV or oral biphosphates for osteoporosis, Paget's disease, bone metastasis or other bone related diseases such as Fosamax (Alendronate), Actonel (Resdronate), Boniva (Ibandronate), or Zometa (Zoledronate)? | ☐ | ☐ |
| 4 Have you had an allergic (or adverse) reaction to any medication or substance? | ☐ | ☐ |
| If yes, please list: _____ | | |
| 5 Have you been a patient in the hospital during the past five years? | ☐ | ☐ |

6 Indicate which of the following you had, or have at present. Place check either yes or no for each of the items below:

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Heart (Surgery, Disease, Attack) | ☐ | ☐ | Ulcers | ☐ | ☐ | Hepatitis A B C | ☐ | ☐ |
| Chest Pain | ☐ | ☐ | Diabetes | ☐ | ☐ | Venereal Disease | ☐ | ☐ |
| Congenital Heart Disease | ☐ | ☐ | Thyroid Problems | ☐ | ☐ | A.I.D.S. | ☐ | ☐ |
| Heart Murmur | ☐ | ☐ | Glaucoma | ☐ | ☐ | H.I.V. Positive | ☐ | ☐ |
| Mitral Valve Prolapse | ☐ | ☐ | Emphysema | ☐ | ☐ | Cold Sores/Fever Blisters | ☐ | ☐ |
| Artificial Heart Valve | ☐ | ☐ | Chronic Cough | ☐ | ☐ | Blood Transfusion | ☐ | ☐ |
| Rheumatic Fever | ☐ | ☐ | Tuberculosis | ☐ | ☐ | Bleeding Problem | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | Asthma | ☐ | ☐ | Sickle Cell Anemia | ☐ | ☐ |
| Heart Pacemaker | ☐ | ☐ | Hay Fever | ☐ | ☐ | Bruise Easily | ☐ | ☐ |
| Arthritis/Rheumatism | ☐ | ☐ | Latex Sensitivity | ☐ | ☐ | Liver Disease | ☐ | ☐ |
| Cortisone Medicine | ☐ | ☐ | Allergies or Hives | ☐ | ☐ | Neurological Disorders | ☐ | ☐ |
| Swollen Ankles | ☐ | ☐ | Sinus Trouble | ☐ | ☐ | Epilepsy or Seizures | ☐ | ☐ |
| Stroke | ☐ | ☐ | Radiation Therapy | ☐ | ☐ | Fainting or Dizzy Spells | ☐ | ☐ |
| Diet (Special/Restriction | ☐ | ☐ | Chemotherapy | ☐ | ☐ | Nervous/Anxious | ☐ | ☐ |
| Artificial Joints (hip, knee, etc.) | ☐ | ☐ | Tumors | ☐ | ☐ | Psychiatric/Psychological Care | ☐ | ☐ |
| 7 Women: Are you Pregnant? | ☐ | ☐ | Nursing? | ☐ | ☐ | Taking birth control pills? | ☐ | ☐ |

| | | |
|---|---|---|
| 8 Do you have any problems being reclined horizontally? | ☐ | ☐ |
| 9 Have you unintentionally gained or lost more than 10 lbs in the past year? | ☐ | ☐ |
| 10 Do you have or have you had any disease, condition, or problem, not listed? | ☐ | ☐ |
| If yes, please list: _____ | | |

I understand the above information is necessary to provide me with the appropriate dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medications.

Patient/Guardian Signature _____ Date _____

Dr. Tang's Notes

Dentist's Signature _____ Date _____

# CONSENT FOR TREATMENT

1. I hereby authorize the dentist or designed staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis of my dental needs.

2. Upon such diagnosis, I authorize the dentist to perform all recommended treatments mutually agreed upon and the dentist to employ such assistance as required to provide the proper care.

3. I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete explanation of any possible complications.

4. I authorize the release of any information concerning my (or my dependent's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

5. I authorize the release of any pertinent information concerning my (or my dependent's) health care and treatment to other dentists or physicians as needed.

6. I authorize the payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

7. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 2.0% late charge (24.0 % APR) or a $15.00 minimum may be added to my account per month.

8. I consent to Dr. Tang's dental office staff using my cell phone number to call or text me regarding appointments and to call regarding treatment, insurance, or financial matters about my account. I understand that I can withdraw my consent at any time or opt out from this automated service.

9. I agree to be on time for all my dental appointments and accept that there may be a $50 service charge per ½ hour of appointment time for broken appointments or cancellations without a full business day (24-hr) notice. For a Monday or Saturday appointment, please call us by Thursday 3 pm for any changes.

Patient Signature _____ Date _____

Parent/Guardian _____ Relationship to Patient _____

# KEITH S. TANG, D.D.S., INC.

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Notice of Privacy Practices. Please check one option below

☑ I give my permission to allow Dr. Tang's and his staff to discuss any information about my dental treatment, medical information, or financial matters with my spouse, significant other, or other authorized person.

_____

☑ I only allow Dr. Tang's and his staff to discuss my dental treatment, medical information, or financial matters with me.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We have attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

□ Individual refused to sign

□ Communication barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented us from obtaining acknowledgement

□ Other (Please Specify)

## Patient Acknowledgement of Receipt of Dental Materials Fact Sheet

I acknowledge that I have received from Keith S. Tang, D.D.S., Inc. a copy of "The Facts About Fillings" dated 5/2004.

Patient Signature Date

*The following document is the Dental Board of California's Dental Materials Fact Sheet. The Department of Consumer Affairs has no position with respect to the language of this form; and its linkage to the DCA web site does not constitute an endorsement of the content of this document.*

# The Dental Board of California Dental Materials Fact Sheet

Adopted by the Board on 5/2004

As required by Chapter 801, Statutes 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 the dentist regarding the selection of dental material 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 ionmer cement, resin-ioner cement, porcelain (ceramic), porcelain-fused to metal, gold alloy (noble) and nickel or cobalt-chrome (base-metal) alloys. Each material has its own advantages and disadvantages, benefits and risks.

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 perception based upon information that predates 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 material 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 the 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.