Topanga Dental, A Practice of Maria Saguin, DDS. INC.

9800 Topanga Canyon Blvd., Suite J Chatsworth,Ca 91311
Phone: (818) 576-0600 Fax: (818) 576-0611
www.topangadental.com

Patient Information **Today's Date:** _____

Patient Name: _____ ☐ Minor ☐ Married ☐ Single/Div/Sep

Home Address of Patient: _____
Street *Apt#* *City* *State* *Zip*

Birthdate: ____/____/_____ Gender: ☐ Male ☐ Female SS# _____-_____-_____

Home Phone: _____ Cell Phone: _____ Work Phone _____

Incase of emergency, person to contact: _____ Phone: _____

Email Address * (Patient/Responsible Party): _____

** We may use this email address to send announcements or promotional materials and requested account information.*

Were you referred by someone to our office, if yes, who? _____

State Identification Number (Driver's License): _____

Responsible Party for the above Patient (If different from above and or if Patient is a minor)

Patient Name: _____ Relation to Patient: _____

Home Address: _____
Street *Apt#* *City* *State* *Zip*

Birthdate: ____/____/_____ SS# _____-_____-_____ Contact Phone: _____

State Identification Number (Driver's License): _____

Dental Insurance Coverage If you do not have Dental Insurance, please check this box: ☐

Name of Employer/School: _____ Phone: _____

Employer Address: _____
Street *Apt#* *City* *State* *Zip*

Dental Ins. #1 _____ Group #: _____ Policy #: _____

Dental Ins. #2 _____ Group #: _____ Policy #: _____

Financial Obligation: Payment (co-payment if using insurance) is expected when services are rendered during your appointment. It is your responsibility to discuss with the administrative staff payment options before treatment begins. All treatment plans and payment options will be provided in writing and signed by the patient or legal guardian.

Other Financial Obligations: You as the patient and/or Responsible party if patient is younger than 18, also agree:

1. To pay all reasonable collection cost and attorney fees in the event of any default of balanced owed.
2. To pay a service charge of **$25** on all returned checks.
3. In the event of an appointment cancellation, when 24 hours notice has not been given, **$35.** charge will be placed on your account.
4. Understand that any estimate given is only guaranteed up to 90 days.

I hereby authorize Topanga Dental to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with proper dental care of the above patient. I, the undersigned, shall be responsible for the payment of charges incurred for the services rendered and shall be responsible for payment in excess of existing insurance coverage. Also permission is granted to perform necessary treatment if patient is a minor.

Patient Signature (Parent if Patient is a minor): _____ Date: _____

Doctor's Signature of Topanga Dental: _____ Date: _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic or bad reaction to any of the following:	☐	☐
○ aspirin, ibuprofen, acetaminophen, codeine _____		
○ penicillin _____		
○ erythromycin _____		
○ tetracycline _____		
○ sulfa _____		
○ local anesthetic _____		
○ fluoride _____		
○ chlorhexidine (CHX) _____		
○ Iodine _____		
○ metals (nickel, gold, silver, _____)		
○ latex _____		
○ nuts _____		
○ fruit _____		
○ milk _____		
○ red dye _____		
○ other _____		
3. heart problems, or cardiac stent within the last six months _____	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic or soft tissue implant (e.g., joint replacement, breast implant) _____	☐	☐
8. heart murmur, rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (or INR > 3.5) _____	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. chronic ear infections, tuberculosis, measles, chicken pox _____	☐	☐
15. breathing problems (e.g., asthma, nasal breathing, stuffy nose, sinus congestion)	☐	☐
16. sleep problems (e.g., sleep apnea, snoring, insomnia, restless sleep, bedwetting) _____	☐	☐
17. kidney disease _____	☐	☐
18. liver disease or jaundice _____	☐	☐
19. vertigo (e.g., "the room is spinning") _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency or imbalance (e.g., polycystic ovarian syndrome) _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive or eating disorders (e.g., gastric reflux, bulimia, anorexia, celiac disease, Crohn's disease, or any inflammatory bowel disease) _____	☐	☐
26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g., bisphosphonates) _____	☐	☐
27. arthritis or gout _____	☐	☐
28. autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma) _____	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (e.g., Alzheimer's disease, dementia, prion disease)	☐	☐
34. viral infections (e.g., cold sores) bacterial infections (e.g., Lyme disease) _____	☐	☐
35. any lumps or swelling in the mouth _____	☐	☐
36. hives, skin rash, hay fever _____	☐	☐
37. STI/STD/HPV _____	☐	☐
38. hepatitis (type ____) _____	☐	☐
39. HIV/AIDS _____	☐	☐
40. tumor, abnormal growth _____	☐	☐
41. radiation therapy _____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. difficulties with stress management _____	☐	☐
44. psychiatric treatment, antidepressants, mood stabilizing medications	☐	☐
45. concentration problems or ADD/ADHD _____	☐	☐
46. alcohol/recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements, vitamins, and/or probiotics _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches or chronic pain _____	☐	☐
53. a smoker, smoked previously or other (e.g., smokeless tobacco, vaping, e-cigarettes, and cannabis) _____	☐	☐
54. considered a touchy/sensitive person _____	☐	☐
55. often unhappy or depressed _____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. diagnosed with a prostate disorder _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) _____

_____

List all medications, supplements, vitamins, and/or probiotics taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ (1-6)

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DENTAL HISTORY

Patient Name _____ Nickname _____ Age _____

Referred by _____ How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor

Previous Dentist _____ How long have you been a patient? _____ Months/Years

Date of most recent dental exam ____/____/____ Date of most recent x-rays ___/____/____

Date of most recent treatment (other than a cleaning) ____/____/____

I routinely see my dentist every ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY	YES	NO
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [___]	☐	☐
2. Have you had an unfavorable dental experience?	☐	☐
3. Have you ever had complications from past dental treatment?	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?	☐	☐
6. Have you had any teeth removed, missing teeth that never developed, or lost teeth due to injury or facial trauma?	☐	☐

GUM AND BONE	YES	NO
7. Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing?	☐	☐
8. Have you ever had or been told you have gum loss, gum disease, or bone loss between your teeth?	☐	☐
9. Have you ever noticed an unpleasant taste, odor in your mouth, or swollen and puffy gums?	☐	☐
10. Is there anyone with a history of periodontal disease in your family?	☐	☐
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth?	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or feel them move when chewing?	☐	☐
13. Have you experienced a burning, painful sensation, or metallic taste in your mouth?	☐	☐

TOOTH STRUCTURE	YES	NO
14. Have you had any cavities within the past 3 years?	☐	☐
15. Does the amount of saliva in your mouth seem too little, not enough, or do you have difficulty swallowing or chewing any food?	☐	☐
16. Do you feel or notice any holes (i.e., pitting, craters) on the biting surface of your teeth?	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
18. Do you have grooves or notches on your teeth near the gum line?	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20. Do you frequently get food caught between any teeth?	☐	☐

BITE AND JAW JOINT	YES	NO
21. Does your jaw joint ever have pain, sounds (popping, cracking), or experience limited opening or locking?	☐	☐
22. Do you feel like you need to pull your lower jaw back, or feel that it is being pushed back when you try to bite your back teeth together?	☐	☐
23. Do you avoid or have difficulty chewing gum, raw carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26. Are your teeth developing spaces or becoming more loose?	☐	☐
27. Do you have more than one bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together better?	☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30. Do you clench or grind your teeth together in the daytime / nighttime or ever make them sore?	☐	☐
31. Do you have any problems with sleep (i.e., restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐	☐
32. Do you wear or have you ever worn a bite appliance?	☐	☐

SMILE CHARACTERISTICS	YES	NO
33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (color, spaces, size, shape, display)?	☐	☐
34. Have you ever bleached (whitened) your teeth?	☐	☐
35. Have you felt uncomfortable or self-conscious about the appearance of your teeth?	☐	☐
36. Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

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TOPANGA DENTAL
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Cosmetic and Family Dentistry

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Patient Preferred Pharmacy Form

In order to better serve you, your prescriptions will now be electronically processed directly to your pharmacy. Please provide us with your pharmacy information in the space below. If you are unable to provide your preferred pharmacy information to us today, you may call us back with the information. Please note that the information is required for any medication prescribed to you by our Dentist.

If at any time there is a change in your pharmacy information, please provide the updated information to our Front Desk Staff.

Patient Name : _____

Pharmacy Name : _____

Pharmacy Address : _____

Pharmacy Phone Number : _____

TOPANGA DENTAL
Maria M. Saguin, DDS, Inc
Cosmetic and Family Dentistry

Dental Materials Fact Sheet

Patient Confirmation of Receipt

Effective January 1, 2002, dentists are required by the State of California to provide a copy of the ***Dental Materials Fact Sheet*** to any patient that will be receiving restorative treatment. This confirmation of receipt form must be signed by the patient or the patient's guardian and filed in the patient's chart, acknowledging receipt of the fact sheet. It is not an informed consent document, and the State of California does not endorse the information nor does it recommend a particular course of treatment; this is a matter that remains to be discussed between the patient and his/her dentist. The information contained on the fact sheet is simply intended to educate patients on the various types of materials used by dentists during the course of restorative dental treatment, in a similar manner to package labeling found on most food.

*A partir del 1° de Enero de 2002 se requierirá que todos los dentistas del Estado de California le proveán una copia de los **Factores de Materiales Dentales** a todo paciente que reciba tratamiento restaurativo. Esta confirmación de recibo debe ser firmada por el/la paciente o padre/madre o turor y archivada en el expediente de cada paciente afirmado haber recibido la copie de los Factores. Este documento no es un consentimiento informado y el Estado de California no endosa la información ni recomienda un curso particular de tratamiento; este es un asunto que debe decidirse entre el/la paciente y su dentista. El propósito de la hoja de factores es proveer información para los pecientes con respecto a los diferentes tipos de materiales que unilizan los dentistas durante el curso del tratamiento restaurative de odontologia, de una manera similar a la que se utiliza en las étiquetas de empaque de productos alimenticios.*

Desaforunadamente el Estado de California no ha redactado este documento en Español y no nos ha permitido traducirlo.

_____ _____

Signature of Patient or Guardian of Patient Date

9800 Topanga Canyon Blvd. Suite J
Chatsworth, CA 91311
(818) 576-0600

TOPANGA DENTAL
Maria M. Saguin, DDS, Inc
Cosmetic and Family Dentistry

Acknowledgment of Receipt of Notice of Privacy Policies

* You may refuse to sign this Acknowledgment *

I, (patient name, please print) _____, have received a copy of Topanga Dental's ***Notice of Privacy Practices.***

_____ _____

Signature of Patient or Guardian of Patient Date

OFFICE USE ONLY

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

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please specify):

_____

_____

_____

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