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: ______________

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Medical History of Patient **Patient Name:** ______________________________

Although dental personnel primarily treat the area in and around the mouth, your moth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dental care you will receive. Thank you for answering the following questions:

Question	Yes	No	
Are you under a physician's care now?	☐ Yes	☐ No	If yes, explain: ______________________
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	If yes, explain: ______________________
Have you ever had a serious head injury?	☐ Yes	☐ No	If yes, explain: ______________________
Are you taking any medications, pills, or drugs?	☐ Yes	☐ No	If yes, explain: ______________________
Do you take, or have you taken, Phem-Fen or Redux?	☐ Yes	☐ No	If yes, explain: ______________________
Do you take, or have you taken Fosamax?	☐ Yes	☐ No	If yes, explain: ______________________
Are you on a special diet?	☐ Yes	☐ No	
Do you use tobacco (chewing and/or smoking)?	☐ Yes	☐ No	
Do you use controlled substances?	☐ Yes	☐ No	

Are you allergic to any of the following:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex

☐ Other, if yes, explain: ____

If you are a women, are you...

Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Do you have, or have you had, any of the following medical conditions? (Please mark a choice for each item below).

Condition			Condition			Condition			Condition		
Aids/HIV Positive	☐ Yes	☐ No	Cortisone Medicine	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Recent Weight Loss	☐ Yes	☐ No
Alzheimer's Disease	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Hepatitis A	☐ Yes	☐ No	Renal Dialysis	☐ Yes	☐ No
Anaphylaxis	☐ Yes	☐ No	Drug Addiction	☐ Yes	☐ No	Hepatitis B/C	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Easily Winded	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Rheumatism	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	High Blood Pres.	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Arthritis/Gout	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No	Hives or Rash	☐ Yes	☐ No	Shingles	☐ Yes	☐ No
Artificial Heart Value	☐ Yes	☐ No	Excessive Bleeding	☐ Yes	☐ No	Hypoglycemia	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No	Excessive Thrust	☐ Yes	☐ No	Irregular Heart beat	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Fainting Spells/Dizziness	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Spina Bifida	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Frequent Cough	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No	Stomach/Intes. Dis.	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Frequent Diarrhea	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Breathing Problem	☐ Yes	☐ No	Frequent Headaches	☐ Yes	☐ No	Low Blood Pres	☐ Yes	☐ No	Swelling of Limbs	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No	Genital Herpes	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Chest Pains	☐ Yes	☐ No	Heart Attack/Failure	☐ Yes	☐ No	Pain in Jaw Joints	☐ Yes	☐ No	Tumors or Growths	☐ Yes	☐ No
Cold Sores/Fever Blisters	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Parathyroid Disease	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Congenital heart Disorder	☐ Yes	☐ No	Heart Pace Maker	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Convulsions	☐ Yes	☐ No	Heart Trouble/Disease	☐ Yes	☐ No	Radiation Treatments	☐ Yes	☐ No	Yellow Jaundice	☐ Yes	☐ No

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, explain: ______________________

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To the best of my knowledge, the questions on this page have been accurately answered. I understand that providing incorrect information can be dangerous to the patient's health. it is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: ______________________ **Date:** ____________

Office Use Only - Do not write in this section

1st Appointment at Topanga Dental Doctor Signature: ______________________ Date: ____________