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:

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).

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: _____

_____

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: _____

Dental History

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

- ☐ Sensitivity (hot, cold, 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

Name of Previous Dentist:

_____

City: _____ State: _____

Phone number: _____

What is the most important thing to you about your future smile and dental health?_____

_____

_____

On a scale of 1 -10, with 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? _____

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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.

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.

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.

4. **Temporomandibular Joint Dysfunction (TMD):** I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. 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.

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

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 (Parasthesia) 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.

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 a 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.

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.

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.)

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, follow a healthy diet, avoid tobacco products and follow other recommendations.

I understand that dentistry is not an exact science and that therefore reputable Practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance 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 also understand that no other Dentist other than the treating Dentist nor Bristol Dental & Orthodontics, is responsible for my dental treatment. I acknowledge the receipt of and understand the postoperative instruction and have been given an appointment date to return. I have received the Dental Materials Fact Sheet.

Signature of responsible party or patient (Parent if patient is a minor) Date

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

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(818) 576-0600

TOPANGA DENTAL
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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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COVID-19 Pandemic Emergency Dental Treatment

Notice and Acknowledgement of Risk Form

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.

The COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You could contract COVID-19 from a variety of sources. Our practice wants to ensure you are aware of the additional risks of contracting COVID-19 associated with dental care.

The COVID-19 virus has a long incubation period. You or your healthcare providers may have the virus and not show symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated due to limited availability for virus testing.

Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office.

Dental procedures create water spray which is one way the disease is spread. The ultra-fine nature of the water spray can linger in the air for a long time, allowing for transmission of the COVID-19 virus to those nearby.

You cannot wear a protective mask over your mouth to prevent infection during treatment as your health care providers need access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

Pursuant to statements from the Center for Disease Control (CDC) and the American Dental Association (ADA), non-essential or elective treatment, based on the assessment of our staff, will be rescheduled. According to the ADA, dental emergencies are "potentially life threatening and require immediate treatment to stop ongoing tissue bleeding [or to] alleviate severe pain or infection." The ADA also recommends that urgent dental care which "focuses on the management of conditions that require immediate attention to relieve severe pain and/or risk of infection and to alleviate the burden on hospital emergency departments" be provided in as minimally invasive a manner as possible.

I confirm that I have read the Notice above and understand and accept that there is an increased risk of contracting the COVID-19 virus in the dental office or with dental treatment. I further confirm I am seeking treatment for a condition that meets the emergent or urgent criteria noted above. I understand and accept the additional risk of contracting COVID-19 from contact at this office. I also acknowledge that I could contract the COVID-19 virus from outside this office and unrelated to my visit here.

I have read and understand the information stated above:

_____ _____

Signature Date

_____

Witness

COVID-19 PANDEMIC - PATIENT DISCLOSURES

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	Yes	No
Do you have a fever or above normal temperature?	☐	☐
Have you experienced shortness of breath or had trouble breathing?	☐	☐
Do you have a dry cough?	☐	☐
Do you have a runny nose?	☐	☐
Have you recently lost or had a reduction in your sense of smell?	☐	☐
Do you have a sore throat?	☐	☐
Have you been in contact with someone who has tested positive for COVID-19?	☐	☐
Have you tested positive for COVID-19?	☐	☐
Have you been tested for COVID-19 and are awaiting results?	☐	☐
Have you traveled outside the United States by air or cruise ship in the past 14 days?	☐	☐
Have you traveled within the United States by air, bus or train within the past 14 days?	☐	☐

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

_____ _____

Signature Date

_____

Witness