Patient Information

Dr Bonnie Bateman DDS
Dr Rebekah Coraity DDS

Name _____
Address_____
City_____ State_____ Zip_____
Date of Birth_____ Age_____
Male_ Female _
Social Security #_____
Driver's License #_____
Married_ Single_
Employer_____
Address_____
Position_____

Home#_____
Work# _____
Cell #_____
Email Address:_____

Spouse Information

Name_____ DOB _____
Social Security #_____
Employer #_____
Address _____
Phone#_____ Position _____

*If you have Dental Insurance, please provide the following information so we can assist you in billing your dental insurance carrier:

Primary Carrier

Name of Insured_____
Patient Relationship to Insured_____
SS# or Member ID_____
Insurance Carrier_____
Employer _____
Group #_____

Secondary Carrier

Name of Insured_____
Patient Relationship to Insured_____
SS# or Member ID_____
Insurance Carrier_____
Employer_____
Group#_____

General Information

Person Responsible for Account_____
Relationship to Patient_____
Driver's License #_____
Person to contact in case of emergency :
_____
Their Telephone_____

How did you hear about the office?

_____

Please Fill out Both Sides

Los Altos Dental: 2618 Los Coyotes Diagonal, Long Beach, CA 90803

Medical History

Please Answer All Questions

Please circle Yes or No to the following:

If Yes, Explain:

Rheumatic Fever	NO	YES_____
Heart Murmur	NO	YES_____
High Blood Pressure	NO	YES_____
Circulation Problems	NO	YES_____
Excessive Bleeding	NO	YES_____
Hepatitis	NO	YES_____
Venereal Disease	NO	YES_____
AIDS	NO	YES_____
Anemia	NO	YES_____
Diabetes	NO	YES_____
Kidney Disease	NO	YES_____
Respiratory Disease	NO	YES_____
Tuberculosis	NO	YES_____
Sinus Problems	NO	YES_____
Asthma	NO	YES_____
Hay Fever	NO	YES_____
Ulcers	NO	YES_____
Arthritis	NO	YES_____
Tumors or Growths	NO	YES_____
Radiation Treatment	NO	YES_____
Fainting Spells	NO	YES_____
Nervous Disorders	NO	YES_____
Epilepsy	NO	YES_____
Head/Neck Injuries	NO	YES_____
Stroke	NO	YES_____

Are you in good health?_____

Date of Last medical Exam_____

Have you ever been Hospitalized?_____

If yes, what was the reason_____

Do you wear a cardiac pacemaker?_____

Are you under the care of a physician?

_____

If so, for what?_____

Are you Pregnant?_____

How many months?_____

List any drugs or chemicals you are sensitive to_____

Any allergies to latex?_____

List any drugs you are now taking

_____

Have you ever taken Bisphosphonates?_____

Physician's name_____

Do you have any other disease, problem Or condition that you think the Doctor should know about?_____

_____

Do you smoke?___ If yes, How many packs a day/ for how long?_____

Do you drink alcohol? If yes, what is your weekly intake?_____

Dental History

(Please Answer All Questions)

When was the last time you saw a Dentist?_____

Have you ever had an unfavorable experience with a Dentist?_____

_____

Is there anything we can do to make you feel more comfortable While receiving treatment?

_____ Nitrous Oxide

_____Stereo Headphones

_____ Other_____

When were your last set of x-rays taken?_____

Have you been instructed in the care of your gums?

_____

Have you been treated for periodontal (gum) disease?_____

Do you have any sores, blisters, or swelling on your gums, lips, cheeks?

_____

Do you grind/clench your teeth?_____

Have you ever had any popping or clicking near your ear when you chew?_____

Have you had orthodontic treatment?_____

Do you, or have you had any dental Diseases/ problems that haven't been Mentioned?_____

Explain:_____

I authorize the dentist to perform . diagnostic procedures and treatment as may be necessary for proper dental care. I attest to the accuracy of the information on this form.

Patient or Guardian's Signature:_____ Date _____

I certify that I have reviewed the medical history with the patient:_____ Date _____

Doctor's signature

- Post treatment swelling of the gum area in the vicinity of the treated tooth or facial swelling, either of which may persist for several days or longer.
- Infection.
- Restricted jaw opening.
- Breakage of root canal instruments during treatment, which may in the judgement of the doctor, be left in the treated root canal or bone as part of the filling material; or it may require surgery for removal.
- Perforation of the root canal with instruments, which may require additional surgical treatment or result in premature tooth loss or extraction.
- Risk or temporary or permanent numbness in treatment area.

If an "open and medicate" or pulpotomy procedure is performed, I understand that this is not permanent treatment, and I need to pay for, and finish final root canal therapy. If root canal treatment is not finalized I expose myself to infection and/or tooth loss.
If failure of root canal therapy occurs, the treatment may have to be redone, root-end surgery may be required, or the tooth may have to be extracted.

6. CROWN AND BRIDGE Initials: _____

- I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I understand that at times, during the preparation of a tooth for a crown, pulp exposure may occur, necessitating possible root canal therapy.
- I understand that like natural teeth, crowns and bridges need to be kept clean, with proper oral hygiene and periodic cleanings, otherwise decay may develop underneath and/or around the margins of the restoration, leading to further dental treatment.

7. DENTURES – COMPLETE OR PARTIAL Initials: _____

- The problems of wearing dentures have been explained to me including looseness, soreness, and possible breakage, and relining due to tissue change. Follow-up appointments are an integral part of maintenance and success of a prosthetic appliance. Persistent sore spots should be immediately examined by the doctor.
- I further understand that surgical intervention (i.e. tori removal, bone recontouring or implants) may be needed for dentures to be properly fitted. I also understand that due to bone loss or other complicating factors, I may never be able to wear dentures to my satisfaction.

8. PEDODONTICS (CHILD DENTISTRY) Initials: _____

- I understand that the following procedures are routinely used at Los Altos Dental, as well as being accepted procedures in dental profession.
- POSITIVE REINFORCEMENT – Rewarding the child who portrays desirable behavior, by use of compliments, praise, a pat or hug, and/or token objects or toys.
- VOICE CONTROL – The attention of a disruptive child is gained by changing the tone or increasing the volume of the doctor's voice.
- PHYSICAL RESTRAINT – Restraining the child's disruptive movements by holding down their hands, upper body, head and/or legs by use of the dentist's or assistant's hand or arm.
- NITROUS OXIDE AND/OR ORAL SEDATION – Nitrous oxide is mild gas that is mixed with oxygen, and is used to sedate a person. It is administered through a mask placed over the child's nose. Oral sedations are medications administered to children to help them relax. With their use, the parent and/or guardian must understand that the child should NOT eat or drink for a period of four hours prior to the sedation appointment. The parent/guardian must be available to escort the child home after sedation procedure, and observe their behavior throughout the day.

I understand that with the use of an injection, used to numb the tooth for dental procedures, the possibility exists that the child may inadvertently bite their lip causing injury to occur.
I understand the need to return to the office, for evaluation, if swelling and/or pain in my child does not go away after a sufficient period of time.
I understand the need to return to the office within three months following nerve treatment of a "baby tooth" for evaluation, and possibility of it then needing extraction.

* READ HERE*

I UNDERSTAND THAT NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN THAT THE PROPOSED TREATMENT WILL BE CURATIVE AND/OR SUCCESSFUL TO MY COMPLETE SATISFACTION. I AGREE TO COOPERATE COMPLETELY WITH THE RECOMMENDATIONS OF THE DOCTOR WHILE I AM UNDER HIS CARE, REALIZING THAT ANY LACK OF SAME COULD RESULT IN LESS THAN OPTIMUM RESULTS.
I CERTIFY THAT I HAVE HAD THE OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE, INCLUDING THE OPPOSING SIDE OF THE DOCUMENT, AND CONSENT TO THE OPERATION AND EXPLANATION REFERRED TO OR MADE. I HAVE BEEN ENCOURAGED TO ASK QUESTIONS, AND HAVE THEM ANSWERED TO MY SATISFACTION.

Signature of Patient/Legal Representative: X _____ Relationship: _____ Date: _____

Doctor: _____ Witness: _____ Date: _____

PATIENT CONSENT TO TREATMENT

1. DRUGS, MEDICATION, AND ANESTHESIA

Initials: _____

- I understand that antibiotics, analgesics, and other medications may cause adverse reactions, some of which are, but are not limited to, redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest.
- I understand that medications, drugs, and anesthetics may cause drowsiness and lack of coordination, which can be increased by the use of alcohol or other drugs. I have been advised not to consume alcohol, nor to operate any vehicle or hazardous device while taking medications and or drugs, or until fully recovered from their effects (this include a period of at least twenty-four (24) hours after my release from surgery).
- I understand that occasionally, upon injection of a local anesthetic, I may have prolonged persistent anesthesia, numbness, and/or irritation to the area of injection.
- I understand that if I select to utilize Nitrous Oxide, "Atarax", Chloral Hydrate, "Zanax", or any sedative, possible risk include, but are not limited to, loss of consciousness, obstruction of airway, anaphylactic shock, and cardiac arrest. I understand that someone needs to drive me home from the dental office after I have received sedation. I also understand that someone needs to watch me closely for a period of 8 to 10 hours, following my dental appointment, to observe possible deleterious side effects, such as obstruction of airway.

2. HYGIENE AND PERIODONTICS (TISSUE AND BONE LOSS)

Initials: _____

- I understand that the long term success of treatment and status of my oral condition depends on my efforts at proper oral hygiene (i.e. brushing and flossing) and maintaining regular recall visits.
- PERIODONTICS. I understand that I have serious condition, causing gum and bone inflammation and/or loss, and that it can lead to loss of my teeth and other complications. The various treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I also understand that although these treatments have a high degree of success, they cannot be guaranteed. Occasionally treated teeth may require extraction.

3. REMOVAL OF TEETH

Initials: _____

- I understand that the purpose of the procedure/surgery is to treat and possibly correct my diseased oral tissues. The doctor has advised me that if this condition persists without treatment or surgery, my present oral condition will probably worsen in time.
- POTENTIAL RISKS INCLUDE, BUT ARE NOT LIMITED TO, THE FOLLOWING:
- Post-operative discomfort, swelling, delayed healing (dry socket) and/or infection (requiring prescriptions or additional treatment, i.e. surgery)
  Injury to adjacent teeth, caps, or fillings (requiring the recementation of crowns, replacement of fillings, fabrication of crowns or extraction), or injury to other tissues not within described surgical area.
- Limitation of opening: stiffness of facial and/or neck muscles: change in bite: or temporomandibular joint (jaw joint) difficulty (possibly requiring physical therapy or surgery)
- Residual root fragments or bone spicules left when complete removal would require extensive surgery or needless complications.
- Possible bone fracture which may require wiring or surgical treatment.
- Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.
- Injury to the nerve underlying the teeth resulting in itching, numbness, or burning of the lip, chin, gums, cheek, teeth, and/or tongue on the operated side; this may persist for several weeks, months, or, in remote instances, permanently.

I give my consent for the doctor to perform the treatment/procedure/surgery previously explained to me, or other procedures deemed necessary or advisable as necessary to complete the planned operation.
If any unforeseen condition should arise in the course of the operation, calling for the doctor's judgement or for procedures in addition to or different from those now contemplated. I request and authorize the doctor to do whatever he deem advisable, including referral to another dentist or specialist. I also understand that the cost of this referral would be my responsibility.

4. FILLINGS

Initials: _____

- I have been advised of the need for fillings, either silver or composite (plastic), to replace tooth structure lost to decay. I understand that with time fittings will need to be replaced due to wearing of material. In cases where very little tooth structure remains, or existing tooth fractures off, I may need to receive more extensive treatment (such as root canal therapy, post and build-up, and crowns), which would necessitate a separate charge.
- I understand that silver amalgam restoration is an acceptable procedure according to the American Dental Association guidelines and, as such, is a treatment used by Los Altos Dental. The advantages and disadvantages of alternate materials have been explained to me.

5. ENDODONTIC THERAPY (ROOT CANAL THERAPY)

Initials: _____

- The purpose and method of root canal therapy have been explained to me, as well as reasonable alternative treatments, and the consequences of non-treatment. I understand that following root canal therapy my tooth will be brittle and must be protected against fracture by replacement of a crown (cap) over the tooth.

I UNDERSTAND THAT TREATMENT RISK CAN INCLUDE, BUT ARE NOT LIMITED TO THE FOLLOWING:

- Post treatment discomfort lasting a few hours to several days for which medication will be prescribed if deemed necessary by the doctor.

Los Altos Dental
Gerald W Ganz, DDS
Bonnie Bateman-Ganz, DDS
2618 Los Coyotes Diagonal
Long Beach, CA 90815
(562) 425-1196

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to providing you with the highest quality of care. The following is a statement of our financial policy which we request that you review carefully and sign prior to treatment.

INSURANCE

You as the patient are responsible to know what insurance plan you have. You must know what dental benefits and coverage you have at the time of your appointment, including any co-payments, deductible and guidelines (pre-authorizations, limitations, etc). **If you do not know what your coverage is, please call your insurance company prior to your appointment date to get the information.**

For all patients with insurance plans for which we are providers, we will bill your insurance company (as a courtesy & at no charge to you). All co-payments and deductibles are due at the time of service. If we find after the appointment that your insurance was not valid, **you are responsible for all fees.**

If we are not a provider for your insurance company, we ask that you please pay at the time of service. We will provide you with a receipt of payment and office fees. You may submit this receipt to your insurance company for reimbursement.

CASH

Payment for all services is due at the time of service.

Thank you for understanding our financial policy. Please let us know if you have any further questions or concerns.

I UNDERSTAND AND AGREE TO THE ABOVE FINANCIAL POLICY.

Patient Signature *Date*