



Westlake Village Dental Health and Wellness

Stanley A. Organ, D.D.S. & Mike S. Choi, D.D.S.

Welcome to our office! Please complete the following confidential information. We sincerely appreciate you choosing us as your dental office. We look forward to helping you become a part of our family of patients.

Date _____

Name _____ / _____ / _____ PREFER TO BE CALLED _____
LAST FIRST M.I.

Address _____ / _____ / _____ / _____
Street City State Zip

Telephone Numbers (____) _____ / (____) _____ / (____) _____
HOME WORK CELL

EMAIL _____

Birthdate _____ Age _____ Social Security Number _____

Sex: (M) (F) Marital Status: (M) (S) (D) (W)

Occupation _____ Employer _____

Insurance Company _____ Group No. _____ Employer Name _____

Guarantor _____ Date of Birth _____ / _____ / _____ Relationship to Patient _____

Person financially responsible for account _____

Insured's I.D. No./SSN _____

You were referred to us by: _____

Person to contact for emergency _____ Phone Number _____

Appointment Agreement

Appointments are made in advance by reserving the appropriate time slots to accommodate you, the patient, and your treatment to be performed. Our staff spends time meticulously preparing for each appointment by sterilizing, organizing and arranging the set up items prior to your arrival. This ensures that we achieve the high standard of care and treatment that we pride ourselves on. We, therefore, require at least **24 hours notice** prior to canceling or rescheduling appointments. Patients who cancel or reschedule their appointment without proper notice will be assessed a \$150.00 fee to offset the lost production time and estimated amount of time effort the staff has already spent preparing for the appointment. We look forward to accomplishing all of your treatment needs in a comfortable and caring environment.

➤ Patient's Signature _____

PLEASE TURN OVER



CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostics aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available. I also permit the release of any information to or from my physicians as may be required.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment in full is due at time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1 ½% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date _____ Witness _____

Parent/Responsible Party's Signature _____ Relationship to Patient _____



Dental History

Patient Name _____

What is the reason for your visit today? _____

Date of last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____ Telephone _____

How often do you have dental examinations? _____

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

What other dental aids do you use? (waterpik, electric tooth brush, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or chewing?	Yes	No
Have you noticed any mouth odors?	Yes	No
Do you frequently get cold sores?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum Disease or tooth loss?	Yes	No
Have you noticed any loose teeth or Change in your bite?	Yes	No
Does food tend to become caught in Between your teeth?	Yes	No
If yes, where? _____		

Do you:

Clench or grind your teeth?	Yes	No
Bite your lips or cheek regularly?	Yes	No
Hold foreign objects with your teeth?	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in morning?	Yes	No
Snore or have any other sleeping Disorder?	Yes	No
Smoke or chew tobacco?	Yes	No

Have you ever had an upsetting dental experience? Yes

Have you ever had:

Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground/the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No
If so, please describe, _____		

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (Joint, ear, side of face)?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches, shoulder aches?	Yes	No

Are you Satisfied wit your teeth's appearance?

Would you like to keep all your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No
If so, what is your biggest concern? _____		

No If yes, please describe? _____

Have you ever been told to take pre-medication prior to dental treatment? Yes No

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

(Please complete other side)

Medical History

Patient Name _____	Medical Alert _____
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1. Physician's Name _____ Phone () _____
2. Have you had any medical care within the past two years?..... Yes No
Describe _____
3. Have you taken any medication or drugs during the past two years?..... Yes No
4. Have you taken antibiotics for an extended period of time? Yes No
5. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin?..... Yes No
If yes, please list name and dosage _____
6. Have you ever taken prescription medications for weight loss (diet pills)?..... Yes No
If yes, did you take any of the following: (circle if yes) Fen-Phen Pondimen Redux Other
If yes to any of the above, did you have a medical exam for heart issues?..... Yes No
7. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs?..... Yes No
8. Have you been a patient in the hospital during the past five years?..... Yes No
9. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)...	Yes	No	Ulcers.....	Yes	No	Hepatitis A B C (circle)	Yes	No
Chest Pain.....	Yes	No	Diabetes.....	Yes	No	Venereal Disease.....	Yes	No
Congenital Heart Disease.....	Yes	No	Thyroid Problems...	Yes	No	A.I.D.S./H.I.V. Positive.....	Yes	No
Heart Murmur.....	Yes	No	Glaucoma.....	Yes	No	Cold Sores/Fever Blisters..	Yes	No
High/Low Blood Pressure.....	Yes	No	Contact Lenses.....	Yes	No	Blood Transfusion.....	Yes	No
Mitral Valve Prolapse.....	Yes	No	Emphysema.....	Yes	No	Hemophilia.....	Yes	No
Artificial Heart Valve/Pacemaker	Yes	No	Chronic Cough.....	Yes	No	Sickle Cell Disease.....	Yes	No
Rheumatic Fever.....	Yes	No	Tuberculosis.....	Yes	No	Bruise Easily.....	Yes	No
Arthritis/Rheumatism.....	Yes	No	Asthma.....	Yes	No	Liver Disease/Yellow Jaundice.	Yes	No
Cortisone Medicine.....	Yes	No	Hay Fever/Allergy/Hives	Yes	No	Neurological Disorders.....	Yes	No
Swollen Ankles.....	Yes	No	Latex Sensitivity.....	Yes	No	Epilepsy or Seizures.....	Yes	No
Stroke.....	Yes	No	Sinus Trouble.....	Yes	No	Fainting or Dizzy Spells.....	Yes	No
Diet (Special/Restricted).....	Yes	No	Radiation Therapy....	Yes	No	Nervous/Anxious.....	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy.....	Yes	No	Psychiatric/Psychological Care	Yes	No
Kidney Trouble.....	Yes	No	Tumors.....	Yes	No			

10. Are you aware of having an allergic (**or adverse**) reaction to any substance or medication?..... Yes No
11. Have you lost or gained more than 10 pounds in the past year?..... Yes No
12. Do you have or have you had any disease, condition, or problem not listed?..... Yes No
If yes, please list: _____
13. **Women:** Are you pregnant or think you could be pregnant? Yes ___Months No **Nursing?** Yes No
14. Do you use birth control prescriptions?..... Yes No

I understand the above information is necessary to provide me with 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 your. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

Dentist Signature _____ Date _____