EL DORADO HILLS
TOWN CENTER DENTAL

Patient Information

Name: *Last* *First* *Middle Initial* | Preferred Name: | Title (Mr/Ms/Mrs etc.)

Gender: ☐ Male ☐ Female | Family Status: ☐ Married ☐ Single ☐ Child ☐ Other | Date of Birth: | Previous Visit:

Email Address: | Home Phone: *Include area code* ( ) | Work Phone: *Include area code* ( ) Ext. | Cell Phone: *Include area code* ( ) | Best time to call:

Address: *Mailing address* | City: | State: | Zip:

Preferred appointment times: | SSN: | DL #:

☐Mon ☐Tue ☐Wed ☐Thurs ☐Fri ☐Sat ☐ Morning ☐ Afternoon ☐ Evening ☐ Any time

Whom may we thank for referring you to our practice? | Name of person, office, or other source referring you to our practice:

☐Dental Office ☐Yellow Pages ☐Internet ☐Newspaper ☐School ☐Work ☐Other

Spouse or Responsible Party Information

The following is for: | SSN: | DL #:

☐ The patient's spouse ☐ The person responsible for payment ☐ Neither applicable

Name: *Last* *First* *Middle Initial* | Preferred Name: | Date of Birth:

Email Address: | Home Phone: *Include area code* ( ) | Work Phone: *Include area code* ( ) Ext. | Cell Phone: *Include area code* ( ) | Best time to call:

Address: *Mailing address* | City: | State: | Zip:

Employment

The following is for:

☐ The patient's spouse ☐ The person responsible for payment

Employer Name: | Phone: ( )

Address: *Mailing address* | City: | State: | Zip:

Primary Insurance Information

Primary Dental Insurance:

Name of the Insured: *Last* *First* *Middle Initial* | Date of Birth: | ID #: | Group #:

Insured's Address: *Mailing address* | City: | State: | Zip:

Insured's Employers Name:

Employer's Address: *Mailing address* | City: | State: | Zip:

Patient's relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other | Insurance Plan Name:

Insurance Address: *Mailing address* | City: | State: | Zip:

Primary Medical Insurance:

Name of the Insured: *Last* *First* *Middle Initial* | Patient's relationship to insured ☐Self ☐ Spouse ☐ Child ☐ Other | Insurance Plan Name:

Secondary Insurance Information

Secondary Dental Insurance:

Name of the Insured: Date of Birth: ID #: Group #:

Last *First* *Middle Initial*

Insured's Address: City: State: Zip:

Mailing address

Insured's Employers Name:

Employer's Address: City: State: Zip:

Mailing address

Patient's relationship to insured Insurance Plan Name:

☐Self ☐ Spouse ☐ Child ☐ Other

Insurance Address: City: State: Zip:

Mailing address

Secondary Medical Insurance:

Name of the Insured: Patient's relationship to insured Insurance Plan Name:

Last *First* *Middle Initial* ☐ Self ☐ Spouse ☐ Child ☐ Other

Handle me with care

Put a checkmark in the box next to the statement that concerns or descibes you:

- ☐ I gag easily
- ☐ I feel out of control while I'm lying down in the dental chair
- ☐ I have not been to a dentist for a long time and I am worried about what you will tell me about my teeth and my dental hygiene
- ☐ I am embarrassed about the way my teeth look
- ☐ I have had a bad dental experience and have a lot of fear which has kept me from getting the dental care I need
- ☐ I am very apprehensive about the possibility of experiencing any pain. Therefore, pain relief is a top priority for me
- ☐ Please tell me what I need to know about my mouth so that I can make informed decisions
- ☐ I want to be able to ask as many questions as necessary so that I understand why and what treatment is being recommended for me
- ☐ I have difficulty listening and remembering when I am in the dental chair
- ☐ I would like to see pictures and videos that will help me understand my dental problems and their solutions
- ☐ I will need help with financing options so that I can spread my payments out over time
- ☐ Other

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have been provided a copy of Dr. Mantena's Notice of Privacy Practices, which has an effective date of 9/23/13, and which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

Signature of patient or patient's representative Date:

Print Name Relationship to Patient (if not signed by the patient)

Name of family member or representative that Dr. Mantena can release information to

Thank you for choosing our office to meet your dental needs.

We make every effort to give the perfect patient experience. For your comfort we offer nitrous oxide (laughing gas) and sedation dentistry. Please let us know if you would be interested in either of those options. We also have pillows, blankets, TV's, music and wireless earphones available. Shortly after completing your professional cleaning or treatment with the Dr. you will be provided with a warm towelette.

To assure that you receive the best dental care in an efficient and timely manner we reserve appointments exclusively for you. If you need to change or cancel an appointment please notify us within 48 hours to avoid a $75.00 cancellation fee. If an appointment is cancelled or failed multiple times a deposit may be required to reserve your future appointments.
We strive to provide excellent customer service and satisfaction. If you ever feel that you were given less than excellent service, we ask that you inform us immediately. Your feedback is important to us.

We look forward to serving you and appreciate your patronage.

Signature Date: Print Name

Dental insurance is a contract between the patient or employer with the insurance company. The dental office has no control of payments or reimbursement by the insurance company. We will make every effort possible to assist you with your particular coverage. Although it is not required, we will prepare and submit your insurance claim at no cost as a courtesy to our patient. We will also provide an "ESTIMATE" of cost that is due at the time of treatment. Should our "ESTIMATE" be too high, a refund will be issued. Likewise, if the "ESTIMATE" was low, the remainder will be due at that time. Should no insurance payment be made within ninety days of a submitted claim, the fee will become the sole responsibility of the patient.

Patient's name (please print) Signature of patient or legal guardian

DENTAL HISTORY

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:	**YES**	**NO**
PERSONAL HISTORY		
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		
7. Do your gums bleed or are they painful when brushing or flossing? _____	☐	☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____	☐	☐
10. Is there anyone with a history of periodontal disease in your family? _____	☐	☐
11. Have you ever experienced gum recession? _____	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____	☐	☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____	☐	☐
TOOTH STRUCTURE		
14. Have you had any cavities within the past 3 years? _____	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing 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		
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	☐	☐
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? _____	☐	☐
23. Do you avoid or have difficulty chewing gum, 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 trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? __	☐	☐
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 or 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		
33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? _____	☐	☐
34. Have you ever whitened (bleached) 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 _____

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		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ nuts _____		
☐ fruit _____		
☐ 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 implant (joint replacement) _____	☐	☐
8. 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 (INR > 3.5) _____	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis ___	☐	☐
14. tuberculosis, measles, chicken pox _____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) ___	☐	☐
27. arthritis _____	☐	☐
28. autoimmune disease _____ (i.e. rheumatoid arthritis, lupus, scleroderma)	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
34. viral infections and cold sores _____	☐	☐
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. emotional difficulties _____	☐	☐
44. psychiatric treatment _____	☐	☐
45. antidepressant medication _____	☐	☐
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 (i.e. fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches _____	☐	☐
53. a smoker, smoked previously or use smokeless tobacco ___	☐	☐
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, and or vitamins 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)