GOLDEN TRIANGLE DENTAL
21700 GOLDEN TRIANGLE ROAD SUITE 201
SAUGUS, CA. 91350
661-259-5540 FAX 661-259-5571

The Dental Board of California Dental Material Fact Sheet

As required by the Dental Board of California, I acknowledge that I have received a copy of the Dental Material Fact Sheet.

____
Patient's Name (Print Name)

______________________________ ____________
Patient's Signature Date

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Date: ______________________

You have the right to refuse to sign this Acknowledgement

I, ____, have
(Signature of Patient)

received a copy of this office's *NOTICE OF PRIVACY PRACTICES* as required by federal law.

____
Print Patient's Name

____
Patient's Signature

FOR OFFICE USE ONLY

On the date above we made a "good faith effort" to obtain written acknowledgement of receipt of our *NOTICE OF PRIVACY PRACTICES.* We were unable to obtain acknowledgement for the following reason:

☐ Patient refused to sign

☐ Other ____
(Possible reasons: Language difficulty, communication barriers, dental emergency)

____
(Printed Name)

____
(Signature of employee attempting to gain acknowledgement)

Date: ____________

Acct # ____________

Cell Phone # ____________

CONFIDENTIAL PATIENT INFORMATION

Please Print Clearly

I. Patient Information

Name: ____________ Birthdate: ________ Gender: ____________
Address: ____________ City & State: ____________ Zip Code: ____________
Home Phone: ( ) ________ Work Phone: ( ) ________ E-mail: ____________
Social Security: ____________ Driver's License # ____________
Employer's Name: ____________ Phone Number: ( ) ____________

II. Responsible Party (Primary Insurance Information)

Name ____________ Relationship to Patient: ____________
Social Security # ___ - ___ - ___ Drivers Lic # ____________ Birthdate: ____________
Name of Employer: ____________ Phone #: ____________
Address: ____________ City: ____________ Zip Code: ____________
Name of Insurance Company: ____________ Phone #: ____________
Union/Local: ____________ Group Number: ____________
Occupation: ____________ Date of Hire: ____________

III. Second Insurance Information (Complete this section if patient is covered by another insurance company)

Name of the Insured : ____________ Relationship to Patient: ____________
Social Security: ___ - ___ - ___ Drivers Lic #: ____________ Birthdate: ____________
Name of Employer: ____________ Phone #: ____________
Address: ____________ City & State: ____________ Zip Code: ____________
Name of Insurance Company ____________ Phone # ( ) ____________
Union/Local: ____________ Group #: ____________
Occupation: ____________ Date of Hire: ____________

IV. Getting to Know You and Your Family

How did you hear about Golden Triangle Dental? ____________ Last dental x-rays taken? ____________
When was last dental visit? ____________ What treatment was performed? ____________

Please list all immediate family members:

Name:	Relationship:	Birthdate	Date of last dental visit

V. Emergency Contact (Friend or relative not living with you)

Name : ____________ Telephone: ( ) ____________

So we may bill your insurance directly, please sign.

I hereby authorize payment directly to Golden Triangle Dental of the insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by my insurance. I authorize dental care and the release of any information necessary to bill my insurance carrier. In the event of default, I understand that I will be charged and I agree to pay all reasonable collection charges and/or attorney fees.

____________ (Signature of the Insured/Responsible Party)

FOR SIX MONTH RECALL ONLY

I hereby confirm there have been no changes to the above information.

Signature of the responsible party ____________ Date ____________

MEDICAL HISTORY

Have you ever taken fen-phen or a medication containing bisphosphonates? YES / NO

Patient's Name:________________ Age:______ Chart #:__________

1. Is patient in good health? ☐ Yes ☐ No If No, explain ________________
2. Physician's Name:________________ Phone Number:________________
   Is patient under a physician's care now? ☐ Yes ☐ No If Yes, explain ________________
3. Is patient taking any prescribed or over the counter medication? Birth control medications? ☐ Yes ☐ No
   If Yes, list medications: ________________
4. Is the patient pregnant?________ If so, how many months? ________
5. Has patient taken any weight loss medications? (e.g. PhenFen) ☐ Yes ☐ No
6. Has patient ever had a blood transfusion? ☐ Yes ☐ No
7. Does the patient smoke? ☐ Yes ☐ No Use tobacco? ☐ Yes ☐ No Use recreational drugs? ☐ Yes ☐ No
8. Has the patient ever had a allergic reaction to local anesthetic (e.g novacaine)? ☐ Yes ☐ No
9. Is the patient allergic to any medication (e.g. penicillin)? ☐ Yes ☐ No
10. Is the patient allergic to latex? ☐ Yes ☐ No
11. Has the patient ever had prolonged bleeding after an injury or extraction? ☐ Yes ☐ No
12. Does the patient have a cardiac pacemaker or artificial heart valve? ☐ Yes ☐ No
13. Is there any family history of diabetes, heart murmur/problems, tumors? ☐ Yes ☐ No
14. Does the patient's jaw pop or click when chewing? (TMJ) ☐ Yes ☐ No
15. Are you pleased with the appearance of your smile? ☐ Yes ☐ No
    If no, explain ________________
16. Does the patient have any missing teeth? ☐ Yes ☐ No If yes, does the patient have an appliance? ☐ Yes ☐ No
    What type?________ Year made________ Is it comfortable? ☐ Yes ☐ No
17. Please check each box, yes or no, if the patient has ever had any illness or conditions listed below. Please do not leave it blank.

Y N	Y N	Y N	Y N
☐ ☐ AIDS/HIV	☐ ☐ Allergies	☐ ☐ Anemia	☐ ☐ Angina
☐ ☐ Arthritis	☐ ☐ Artificial Joint	☐ ☐ Asthma	☐ ☐ Bleeding Disorders
☐ ☐ Cancer	☐ ☐ Chemotherapy	☐ ☐ Cold Sores	☐ ☐ Diabetes
☐ ☐ Dizzy Spells	☐ ☐ Emphysema	☐ ☐ Epilepsy	☐ ☐ Emotional Disorder
☐ ☐ Fainting	☐ ☐ Fever Blisters	☐ ☐ Glaucoma	☐ ☐ Heart Attack
☐ ☐ Heart Bypass	☐ ☐ Heart Murmur	☐ ☐ Heart Problems	☐ ☐ Heart Surgeries
☐ ☐ Hepatitis	☐ ☐ High Blood Pressure	☐ ☐ HIV Positive	☐ ☐ Immunosuppressed
☐ ☐ Jaundice	☐ ☐ Kidney Disease	☐ ☐ Liver Problems	☐ ☐ Low Blood Pressure
☐ ☐ Lung Disease	☐ ☐ Nervous/Mental Disorder	☐ ☐ Psychiatric Treatment	☐ ☐ Radiation Therapy
☐ ☐ Rheumatic Fever	☐ ☐ Sinus Trouble	☐ ☐ Stroke	☐ ☐ Thyroid Problems
☐ ☐ Tuberculosis	☐ ☐ Venereal Disease		

18. Has patient had any disease, serious illness/surgery, condition or problem not listed above. ☐ Yes ☐ No If Yes, explain ________

To the best of my knowledge, I have answered every question completely and accurately. I will inform my orthodontist of any change in my health and/or medication. I further certify that I consent to the performing of x-rays and oral examination.

________________ ________________
Patient's Signature/responsible party if patient is a minor Date

For Doctors Use Only

Health History Reviewed By ________________(Doctor's Signature) Date________

Comments:________________

RECALL REVIEW: 6 MONTHS

Any changes in health history ☐ No ☐ Yes, please list changes ________

Patient's Signature ________ Date ________
Doctor's Signature ________ Date ________

RECALL REVIEW: 12 MONTHS

Any changes in health history ☐ No ☐ Yes, please list changes ________

Patient's Signature ________ Date ________
Doctor's Signature ________ Date ________

RECALL REVIEW: 18 MONTHS

Any changes in health history ☐ No ☐ Yes, please list changes ________

Patient's Signature ________ Date ________
Doctor's Signature ________ Date ________

RECALL REVIEW: 24 MONTHS

Any changes in health history ☐ No ☐ Yes, please list changes ________

Patient's Signature ________ Date ________
Doctor's Signature ________ Date ________