

Dr. Juan Angulo
41680 Ivy Street, Suite C
Murrieta, CA 92562

Patient Name: _____ Date Of Birth: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Social Security Number: _____
Minor _____ Single _____ Divorced _____ Seperated _____ Married _____ Widowed _____
Cell Phone Number: _____ Home Phone Number: _____
Email Address: _____
Preferred Method Of Communication: Home ___ Cell ___ Email ___ Text ___
How Would You Like To Receive Your Appointment Reminders: Home ___ Cell ___ Email ___ Text ___
If Patient Is A Minor List Responsible Party: _____
Patients Employer: _____
Spouse Name: _____ Date Of Birth: _____
Spouse Social Security Number: _____
Spouse Employer Name: _____
In Case Of Emergency, Contact: _____
Phone Number: _____ Relationship To Patient: _____
Who May We Thank For Referring You: _____

HIPPA PRIVACY RULE

Consent, information disclosure, and insurance authorization all information provided by the patient is deemed private under the health insurance portability and accountability act (HIPPA) and will be used as follows only with the patient consent. I hereby authorize Dr. Juan Angulo to furnish information to other providers, health care treatment facilities, and my insurance companies for purpose of treatment, payment, and health care operations. I hereby assign to the physician all payments for dental services rendered to myself and/or my dependants. I understand that I am responsible for any amount not covered by insurance.

Signature: _____ Date: _____

Insurance Information:

Do You Have Dental Insurance: Yes / No

Primary Dental Insurance Information:

Name Of Insured: _____ Relationship To Insured: _____
Insured Social Security Number: _____ Insured Birth Date: _____
Name Of Policy Holders Employer: _____
Name Of Insurance Company: _____
Phone Number Of The Insurance: _____
Address Of Insurance Company: _____
Group Number: _____ ID Number: _____

Do You Have A Secondary Insurance: Yes / No

Name Of Insured: _____ Relationship To Insured: _____
Insured Social Security Number: _____ Insured Birth Date: _____
Name Of Policy Holders Employer: _____
Name Of Insurance Company: _____
Phone Number Of The Insurance: _____
Address Of Insurance Company: _____
Group Number: _____ ID Number: _____

Signature: _____ Today's Date: _____

Patient Dental & Medical Health History Information

To our patients: Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat you.

PATIENT INFORMATION			
Last Name:	First Name:	Middle Name:	
Home Phone:	Cell Phone:	Work Phone:	
Email Address:			
Mailing Address:	City:	State:	Zip:
Date of Birth: / /	Gender:		
Occupation:			
Emergency Contact: Name:	Relationship:	Phone:	
If you are completing this form for another person, what is your name and relationship to that person? Name: _____ Relationship: _____			
If executing this form as the patient's personal representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.			
DENTAL HISTORY & SYMPTOMS			
What is the reason for your visit today?			
Are you currently experiencing any dental pain or discomfort? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where?			
When was your last dental exam? / /		What was done at that appointment?	
When was the last time you had dental x-rays taken?			
Please mark an "X" in the box ONLY if this applies to you.			
Is it hard to open your mouth?	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?	<input type="checkbox"/>
Does it hurt to chew, bite or swallow?	<input type="checkbox"/>	If yes, please describe what happened and when it happened: _____	
Do your gums bleed when you brush or floss your teeth?	<input type="checkbox"/>	Have you ever had problems with dental treatment in the past?	<input type="checkbox"/>
Have you ever had periodontal (gum) treatments like scaling and root planing?	<input type="checkbox"/>	If yes, please describe what happened: _____	
Do you have, or have you ever had, any sores or growths in your mouth?	<input type="checkbox"/>	Have you ever had a reaction to, or problem with, dental anesthesia?	<input type="checkbox"/>
Do you clench or grind your teeth?	<input type="checkbox"/>	If yes, please describe what happened: _____	
Does your jaw click, pop or hurt?	<input type="checkbox"/>	Are you unhappy with your smile?	
Do you have earaches or neck pains?	<input type="checkbox"/>	If yes, why? Please mark all that apply:	
Does dental treatment make you nervous?	<input type="checkbox"/>	<input type="checkbox"/> The color of your teeth <input type="checkbox"/> The shape of your teeth <input type="checkbox"/> The position of your teeth	
Have you ever experienced any of these sleep-related breathing disorders?	<input type="checkbox"/>	<input type="checkbox"/> Other. Please describe: _____	
<input type="checkbox"/> Mouth breathing <input type="checkbox"/> Snoring <input type="checkbox"/> Trouble breathing during sleep			
MEDICATIONS & OTHER PRODUCTS/SUBSTANCES			
Please use an "X" to mark your answers to the following questions.			
Are you taking any blood thinners (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin)?			Yes No ?
If yes, what medication are you taking? _____			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are you taking any medication to treat osteoporosis or Paget's disease?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Some commonly-prescribed drugs include alendronate (Fosamax®), risedronate (Actonel®), ibandronate (Boniva®), zoledronate (Reclast®), and denosumab (Prolia®).			
If yes, what medication are you taking? _____			
Are you taking, or scheduled to take, an IV medication to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Some commonly-prescribed drugs include denosumab (Xgeva®), pamidronate (Aredia®) or zoledronate (Zometa®).			
If yes, what medication are you taking? _____ How many years have you been taking it? _____			
Are you taking hormonal replacements ?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Do you use any form of tobacco or nicotine products (cigarettes, cigars, snuff, chew, bidis)?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Do you use vaping products ?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
How many alcoholic beverages do you have per week? _____			
Do you use controlled substances (drugs), including marijuana, for either medicinal or recreational reasons?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
If yes, what substances? _____ If yes, how often is your use? <input type="checkbox"/> Daily <input type="checkbox"/> Several times per week <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally			
Was the substance prescribed by a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for what reason(s)? _____			
Do you take any other prescriptions and/or over-the-counter medicine(s), vitamins, herbs and/or supplements ?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
If yes, please list them here and include information about how much and how often you use each one. _____			
WOMEN ONLY: Are you:			
Taking birth control pills ?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Pregnant ? If yes, number of weeks: _____			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Nursing ? If yes, number of weeks: _____			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

ALLERGIES Please use an "X" to mark your answers to the following questions.

Are you allergic to or have you had an allergic reaction to:	Yes	No	?	Yes	No	?	
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa drugs such as sulfamethoxazole-trimethoprim (Septra, Bactrim), erythromycin-sulfisoxazole, sulfasala-zine (Azulfidine), erythromycin-sulfisoxazole (Eryzole, Pediazole) glyburide (Diabeta, Glynase PresTabs), dapsone, sumatriptan (Imitrex), celecoxib (Celebrex), hydrochlorothiazide (Microzide) and furosemide (Lasix).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever/seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Iodine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Latex (rubber)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Other	<input type="checkbox"/>	<input type="checkbox"/>
Local anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Please describe any "Yes" answers and include information about your experience.		
Metals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL & SURGICAL HISTORY

Date of last physical exam: / / What is your normal blood pressure (systolic, diastolic)?

Doctor's Name: Phone:

Please use an "X" to mark your answers to the following questions.

	Yes	No	?
Are you in good physical health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently being seen or treated by a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has a physician or previous dentist recommended that you take antibiotics before having dental work done?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a serious illness, operation or been hospitalized in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any type (either total or partial) of joint replacement surgery (such as for a hip, knee, shoulder, elbow, finger, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a heart valve replacement or heart surgery ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had an organ or bone marrow/stem cell transplant ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you traveled internationally within the last 30 days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a fever (100.4°F or above) in the last 72 hours?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If you answered yes to any of the above, please explain: _____			

MEDICAL HISTORY SPECIFIC Please use an "X" to mark your answers to the following questions.

Do you have, or have you been diagnosed with, any of the following conditions?		Yes	No	?			Yes	No	?
Heart (Cardiac) Health					Cancer				
Pacemaker/implanted defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Artificial (prosthetic) heart valve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Date of diagnosis: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Previous infective endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Chemotherapy: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Congenital heart disease (CHD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Radiation treatment: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Unrepaired, cyanotic CHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Blood (Circulatory) Health				
Repaired (completely) in last 6 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Repaired CHD with residual defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		If yes, date: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Coronary artery disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Damaged heart valves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Brain (Neurological)/Mental Health				
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart murmur/rhythm disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatic heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Mental health disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Breathing (Respiratory) Health					Neurological disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma (COPD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Post-traumatic stress disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Traumatic brain injury or concussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Autoimmune Disease				
Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		AIDS or HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any disease, condition, or problem that's not listed here? If so, please explain. _____									

MEDICAL SYMPTOMS/GENERAL Please use an "X" to mark your answers to the following questions.

In the past 30 days, have you:	Yes	No	?	Yes	No	?	Yes	No	?	
had pain or tightness in the chest?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	found it hard to catch your breath?	<input type="checkbox"/>	<input type="checkbox"/>	experienced vomiting, diarrhea, chills, night sweats or bleeding?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
coughed up blood or had a cough that lasted longer than 3 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	had a high fever (greater than 101.5°F) for no reason?	<input type="checkbox"/>	<input type="checkbox"/>	had migraines or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
been exposed to anyone with tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	noticed a change in your vision?	<input type="checkbox"/>	<input type="checkbox"/>				
had a rapid or irregular heart beat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	fainted for no reason?	<input type="checkbox"/>	<input type="checkbox"/>				

NOTE: It's important for both the doctor and patient to talk honestly about the patient's health before dental treatment starts.

I have answered the above questions completely, accurately and to the best of my ability.
 Signature of Patient/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

Office Use Only: Medical Alert Premedication Allergies Anesthesia

Reviewed by: _____ Date: _____

DENTAL APPOINTMENT AGREEMENT

PURPOSE

Due to the large number of people who make appointments but fail to show up or fail to give adequate advance notice when canceling them, it has become necessary to have a policy on appointment responsibility. Broken and cancelled appointments waste the doctors, hygienists, and staff's very limited time and hinder the dental program's efforts to improve the oral health status of the people that we serve.

RESCHEDULING APPOINTMENTS

The dental staff understand that sometimes situations arise that require rescheduling of your appointment. If you need to reschedule, please call the dental office as soon as you know that you will not be able to keep the appointment, at least 24 hours before the appointment time.

BROKEN APPOINTMENTS

If you miss a scheduled appointment or cancel it at the last minute, a broken appointment will be recorded in your dental chart. If you are more than 15 minutes late for an appointment, a broken appointment will also be recorded, and you may have to be rescheduled if there is not enough time to complete your procedure. It is not fair to keep other patients waiting because someone showed up late.

If a broken appointment occurs (i.e. not giving 24 hour notice), a charge of up to \$50.00 may be applied to a broken appointment. If more than (3) broken appointments have occurred, our office has the right to dismiss you as a patient.

Our office will try to call you the day before your dental appointment as a courtesy. On some occasions our office will not be able to extend this courtesy to you, so please do not rely on this phone call to remind you of your appointment. It is the patient's responsibility to remember the appointments.

Thank you for your cooperation and understanding of this matter!

Dr. Juan Angulo & Staff

X

Patient Name (Please Print)

Date

X

Patient or Guardian Signature

CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct the dentist Dr. Juan Angulo and/or dental auxiliaries of his choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.
 - A. Preventative hygiene treatment, (prophylaxis) and the application of topical fluoride.
 - B. Application of plastic "sealants" to the grooves of the teeth.
 - C. Treatment of diseased or injured teeth with dental restorations (fillings and/or crowns).
 - D. Replacement of missing teeth with dental prostheses, (bridges, partial dentures, full dentures).
 - E. Removal (extraction) of one or more teeth.
 - F. Treatment of diseased or injured oral tissues (hard and/or soft).
 - G. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.

2. I understand that there are risks involved in this treatment and hereby acknowledge that these risks will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.

3. I will be advised that the success of the dental treatment to be provided will require that the patient and/or parents of the patient follow post operative and post-care instructions of the dentist. I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his auxiliaries must be maintained.

4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those disclosed. I therefore authorize and request the performance of any additional procedures that are deemed necessary are desirable to oral health and well being, in the professional judgement of the dentist.

5. There are possible risks and complications associated with the administration of local anesthetics, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face, and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip or cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medication in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.

6. I authorize the dentist to use photographs, radiographs, other diagnostic materials and treatment records for the purpose of teaching, research and scientific publications.

7. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner, and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.

8. I further understand that this consent will remain in effect until such time that I choose to terminate it.

Date _____ Patients name: _____

Name of parent or guardian: _____

Relationship to patient: _____

Signature of patient or parent/guardian

Date