VICTOR A. UGARTE, D.D.S.
1913 E. 17th Street, Suite 112, Santa Ana, CA 92705
Tel. (714) 953-5340

PATIENT INFORMATION

Last Name: First Name: MI File No.

Date of birth : S.S.# :

Sex: M F Marital Status: Single: Married: Other:

Address:

City: State Zip Code TELEPHONE

Spouse Name: D.O.B.

Emergency contact: Phone Number:

RESPONSIBLE PARTY INFORMATION

Last name: First name: MI:

Date of birth : S.S. #

Sex: M F Marital Status: Single: Married: Other:

Employer and Address:

City: State: Zip Code: TELEPHONE

Relation to Patient Self: Spouse: Parents: Other:

Insurance Company:

Policy #: Group:

Insurance Address:

City: State Zip Code TELEPHONE

Consent Statement: I give full and complete permission to this Dentist to treat myself, my minor child, my spouse, my relatives, or other in my control; I accept full financial responsibility and assign all payment due to the Dentist.

Patient Signature Responsible Party Signature Date

GENERAL DENTISTRY INFORMED CONSENT

NAME_____ FILE # _____

1. WORK TO BE DONE. I understand that I am having the following work done: Fillings_____, Bridges_____, Crowns _____, Extractions_____, Impacted teeth removed_____, Root Canals_____, ~~Other~~ EXAM (Initials _____)

2. DRUGS AND MEDICATIONS. I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphalactic shock (severe allergic reaction). (Initials_____)

3. CHANCES IN TREATMENT PLAN. I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary. (Initials_____)

4. REMOVAL OF TEETH. Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth_____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Parasthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility. (Initials_____)

5. CROWNS. BRIDGES AND CAPS. I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation. I further understand that my gingiva (gums) will be sore until healing time has elapsed and that during this healing time my gingiva around the tooth being capped will shrink (recession), sometimes making the tooth look longer than the natural tooth. (Initials_____)

6. DENTURES - COMPLETE OR PARTIAL. I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. (Initials_____)

7. ENDODONTIC TREATMENT (ROOT CANAL). I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root which does not necessarily effect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). (Initials_____)

8. PERIODONTAL, LOSS (TISSUE & BONE)
I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition. (Initials_____)

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist other than the treating dentist is responsible for my dental treatment.

Signature: _____ Date: _____

_____ _____

ENGLISH

DENTAL HISTORY

Name_____ Date of birth_____ SEX : M F

PLEASE ANWSER ALL OF THE QUESTIONS?

1. Reason for visit _____
2. When was your last visit?_____
3. How often do you brush your teeth?_____
4. What brush texture do you use? Soft Medium Hard

PLEASE CIRCLE YOUR ANSWER:

Yes No 5. Do your gums bleed while brushing?
Yes No 6. Do your gums bleed when flossing?
Yes No 7. Do you feel pain to any of your teeth when brushing?
Yes No 8. Are your teeth sensitive to hot, cold, sweet, or sour foods/liquids?
Yes No 9. Have you noticed any losing of your teeth?
Yes No 10. Does food tend to become caught between your teeth?
Yes No 11. Do you have any sores or lumps in or near your mouth?

Have you ever experienced any of the following problems in you jaw:

Yes No 12. Clicking?
Yes No 13. Pain (joint, ear, side of face)?
Yes No 14. Difficulty in opening or closing?
Yes No 15. Difficulty in chewing?
Yes No 16. Have you had any head, neck, or jaw injuries?
Yes No 17. Do you have frequent headaches?
Yes No 18. Do you clench or grind your teeth while awake or asleep?
Yes No 19. Do you bite your lips or cheeks frequently?

Have you ever had?

Yes No 20. Orthodontic treatment (braces)?
Yes No 21. Oral surgery?
Yes No 22. Gum treatment?
Yes No 23. Your teeth ground or the bite adjusted?
Yes No 24. Worn a bite plane or other appliance?
Yes No 25. Are you satisfied with the appearance of your teeth?
Yes No 26. Have you ever had an upsetting experience in the dental office?
Yes No 27. Is there anything about having dental treatment that bothers you?
Describe:_____
_____

Patients signature_____Date_____ Dr. Initial_____

Dr. Victor A. Ugarte 1913 E. 17th St Ste. 112 Santa Ana Ca 92705 **714-953-5340**

HEALTH HISTORY

ENGLISH

Patient Name:_____ Soc. Sec. No _____

Date of Birth_____

I. CIRCLE APPROPRIATE ANSWER:

1. Yes No Is your general health good? If No, why not?_____
2. Yes No Has there been a change in your health with in the last year? Describe_____
3. Yes No Have you been hospitalized or had serious illness in the past three years? Why?_____
4. Yes No Are you being treated by a physician now? For what?_____
   Date of Medical Exam:_____
5. Yes No Are you in pain now? Describe_____
6. Yes No Chest pain (angina)?
7. Yes No Swollen ankles?
8. Yes No Shortness of breath?
9. Yes No Recent weight loss, fever, night sweats?
10. Yes No Persistent cough, coughing up blood?
11. Yes No Bleeding Problems, Brushing easily?
12. Yes No Sinus problems?
13. Yes No Difficulty swallowing?
14. Yes No Diarrhea, constipation, blood in stools?
15. Yes No Frequent vomiting, nausea?
16. Yes No Difficulty urinating, blood in urine?
17. Yes No Dizziness?
18. Yes No Ringing in the ears?
19. Yes No Headaches?
20. Yes No Fainting spells?
21. Yes No Blurred vision?
22. Yes No Seizures?
23. Yes No Excessive thirst?
24. Yes No Frequent urination?
25. Yes No Dry mouth?
26. Yes No Jaundice (yellow skin)?
27. Yes No Joint pain, stiffness?
28. Yes No Heart disease?
29. Yes No Heart attack, heart defects?
30. Yes No Heart murmur?
31. Yes No Rheumatic fever?
32. Yes No Stroke, hardening of arteries?
33. Yes No High blood pressure?
34. Yes No TB, emphysema, other lung diseases?
35. Yes No Hepatitis, other liver disease?
36. Yes No Stomach problems, ulcers?
37. Yes No Allergies to drugs, foods, **latex**, metal?
38. Yes No Family history of diabetes, heart problems?
39. Yes No AIDS or ARC?
40. Yes No Tumors, cancer?
41. Yes No Eye disease?
42. Yes No Skin disease
43. Yes No Arthritis, rheumatism?
44. Yes No Anemia?
45. Yes No VD (syphilis or gonorrhea)?
46. Yes No Herpes?
47. Yes No Kidney, bladder disease?
48. Yes No Thyroid, adrenal disease?
49. Yes No Diabetes?
50. Yes No Psychiatric care
51. Yes No Radiation treatment?
52. Yes No Chemotherapy
53. Yes No Prosthetic heart valve?
54. Yes No Artificial joint?
55. Yes No Hospitalization?
56. Yes No Blood transfusions?
57. Yes No Surgeries?
58. Yes No Pacemaker?
59. Yes No Contact lenses?

ARE YOU TAKING:

1. Yes No Recreation drugs?
2. Yes No Drugs, medicines, including Aspirin)? Please list:_____
3. Yes No Tobacco in any form?
4. Yes No Alcohol?

WOMEN ONLY:

1. Yes No Are you or could you be pregnant or are you nursing?
2. Yes No Taking birth control pills?

ALL PATIENTS:

1. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
   If so, please explain:_____
2. Yes No Have you ever taken Fen-phen or Redux diet pills?
3. Yes No Are you allergic to penicillin?

Patient
Signature_____ Date_____ Dr.Inicial_____

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VICTOR A. UGARTE, D.D.S.
Family Dentistry
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HIPPA Consent & Acknowledgement Form

I, _____ do hereby Consent and Acknowledge my agreement to
Patient or Guardian

the terms set forth in the "HIPPA INFORMATION FORM" and any subsequent changes in office policy. I understand that this consent and acknowledgement shall remain in force indefinitely. I also acknowledge that I have received the HIPPA Information Form.

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Signature Date

I have received a copy of the Dental Materials Fact Sheet as required by law.

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Signature Date