Huntington Beach Periodontics & Dental Implants
Justin Braga, D.D.S., M.S., A Dental Corporation
18821 Delaware Street, Suite #200 Office: (714) 587-9094
Huntington Beach, Ca. 92648

Health History Questionnaire

The following is confidential information and is for our records only. If you have any questions, please contact one of our staff members. We will be happy to help you.

Name(Last):_____(First):_____ □ Mr. □ Mrs. □ Ms. □ Dr.

Address:_____City:_____State:_____Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Sex: □ Male □ Female Birthdate:_____S.S.#:_____

E-Mail Address (Used only for contacting you regarding your appointments):_____

Which days and times are the best for you to be scheduled? Days:_____ Time:_____

Employer_____Occupation:_____

Spouse/Parent Name:_____Birthdate:_____S.S.#:_____

Person to contact in case of Emergency:_____Phone:_____

REFERRED BY_____

Dental Insurance Claims Information

Dental insurance is a benefit purchased by or for the patient. We cannot be responsible for what you have purchased. As a courtesy we will fill out and file a claim for you, but you are responsible for the entire bill. If the information you supply is incomplete or inaccurate, you will be responsible for full payment to our office and filing with your insurance carrier will be your responsibility.

Insured Name:_____ Subscriber Name_____ □ SELF □ SPOUSE □ PARENT □ OTHER

Employer of Subscriber:_____ Birthdate of Subscriber:_____

S.S.# or ID of Subscriber:_____ Insurance Company Name:_____

Release and Assignment

I hereby authorize release of any information, including the diagnosis and records of any treatments or examination rendered, to my insurance company or companies. This release is solely for the purpose of facilitating billing and reimbursement, directly to the doctor, of benefits to which I am entitled.

SIGNATURE:_____DATE:_____

CONTINUED ON FOLLOWING PAGE

Medical History

ARE YOU ALLERGIC TO OR HAD A REACTION TO ANY OF THE FOLLOWING MEDICATIONS?

Allergy to Latex	□ Yes	□ No	Local Anesthetic (Novocain)	□ Yes	□ No
Penicillin	□ Yes	□ No	Other Antibiotics	□ Yes	□ No
Sulfa Drugs	□ Yes	□ No	Aspirin, Tylenol, Advil, Etc. (circle)	□ Yes	□ No
Barbiturates, Tranquilizers, Sleeping Pills	□ Yes	□ No			

What happens when you take these medications?_____

Any other medications you are ALERGIC TO not listed? If yes, please list_____

_____

ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS?

Antibiotics	□ Yes	□ No	Anticoagulants (Blood Thinners)	□ Yes	□ No
Sulfa Drugs	□ Yes	□ No	Advil	□ Yes	□ No
Cortisone (Steroids, in last 2 years)	□ Yes	□ No	Tranquilizers (Librium, Valium)	□ Yes	□ No
Insulin or Orinase (Diabetic)	□ Yes	□ No	Digitalis or other Heart Medications	□ Yes	□ No
Nitroglycerin	□ Yes	□ No	Decongestants	□ Yes	□ No
Aspirin	□ Yes	□ No	Tylenol	□ Yes	□ No

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING:_____

_____

Please check YES or NO if you are being treated, or have been treated for any of the following:

□ Yes	□ No	Used Phen-Phen	□ Yes	□ No	Ulcers/colitis
□ Yes	□ No	If so, had EKG?	□ Yes	□ No	Kidney dialysis
□ Yes	□ No	Recent Illness	□ Yes	□ No	Bruise Easily
□ Yes	□ No	Heart disease	□ Yes	□ No	Had Heart Surgery
□ Yes	□ No	Heart Attack	□ Yes	□ No	Asthma
□ Yes	□ No	Glaucoma	□ Yes	□ No	Hives
□ Yes	□ No	Angina	□ Yes	□ No	Emphysema
□ Yes	□ No	Frequent swollen ankles	□ Yes	□ No	Tuberculosis
□ Yes	□ No	Chest pain on exertion	□ Yes	□ No	Lung Disease
□ Yes	□ No	Stroke	□ Yes	□ No	Recent cough or cold
□ Yes	□ No	High blood pressure	□ Yes	□ No	Nose obstruction
□ Yes	□ No	Low blood pressure	□ Yes	□ No	Rheumatic fever
□ Yes	□ No	Bronchitis	□ Yes	□ No	Chemotherapy
□ Yes	□ No	Heart Murmur	□ Yes	□ No	Hay Fever
□ Yes	□ No	Mitral Valve Prolapse	□ Yes	□ No	Sinus Trouble
□ Yes	□ No	w/ regurgitation	□ Yes	□ No	Allergies
□ Yes	□ No	Congenital heart lesions	□ Yes	□ No	Cancer
□ Yes	□ No	Artificial Heart Valve	□ Yes	□ No	Radiation therapy
□ Yes	□ No	Heart Pacemaker	□ Yes	□ No	Arthritis / Rheumatism
□ Yes	□ No	Artificial Joints	□ Yes	□ No	Cortisone medication or ACTH
□ Yes	□ No	Blood Disease	□ Yes	□ No	Pain in jaw joints / TMJ
□ Yes	□ No	Anemia	□ Yes	□ No	Thyroid Disease
□ Yes	□ No	Bleeding tendencies	□ Yes	□ No	Glandular disease
□ Yes	□ No	AIDS / ARC / HIV+	□ Yes	□ No	Diabetes
□ Yes	□ No	Hepatitis A, B, C or other	□ Yes	□ No	Epilepsy
□ Yes	□ No	Infectious mononucleosis	□ Yes	□ No	Fainting spells or dizzy spells
□ Yes	□ No	Blood Transfusion	□ Yes	□ No	Cold sores
□ Yes	□ No	Liver disease / Jaundice	□ Yes	□ No	Active Herpes
□ Yes	□ No	Hemophilia	□ Yes	□ No	Venereal Disease
□ Yes	□ No	Kidney Trouble	□ Yes	□ No	Alcohol/ Drug Addiction Treatment
□Yes	□ No	Psychiatric Care			
□ Yes	□ No	Do you smoke? How many per day?			
□ Yes	□ No	Are you on a special diet? What kind?			

Family Physician_____

Have you been hospitalized in the past 5 years? □ Yes □ No

If yes, what was the problem?_____

Are you presently under the care of a physician? □ Yes □ No

Doctor's Name / Address / Phone #_____

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Females ONLY:

Are you Pregnant?	□ Yes	□ No
Trying to become Pregnant?	□ Yes	□ No
Taking Oral Contraceptives?	□ Yes	□ No

DENTAL HEALTH

Please check YES or NO if you are being treated, or have been treated for any of the following:

□ Yes □ No Do you consider yourself in good dental health?
□ Yes □ No Do you think that your teeth are affecting your health in any way?
□ Yes □ No Are you dissatisfied with the appearance of your teeth?
□ Yes □ No Are you dissatisfied with your chewing ability?

Have you ever had:

_____Orthodontic Treatment (Braces)
_____Oral Surgery (Extractions)
_____Periodontal Treatment
_____Your bite adjusted
_____A bite plate or other dental appliances

□ Yes □ No Have you noticed any loosening of your teeth?
□ Yes □ No Does food tend to get caught between your teeth?
□ Yes □ No Do you suffer from pain and/or swelling of your gums?
□ Yes □ No Do your gums often bleed when you brush your teeth?
□ Yes □ No Do you have an unpleasant odor or taste in your mouth?
□ Yes □ No Are you missing any teeth?
Reasons: Decay ( ) Gum Disease ( ) Other ( )
□ Yes □ No Have missing teeth been replaced?
□ Yes □ No Do you have any soreness, pain, clicking or popping in the area in front of your ears?

When did you last have your teeth cleaned before this appointment?_____
How long before that?_____
How often do you see your dentist?_____
How often and when do you brush your teeth?_____
Do you use: Hand toothbrush ( ) Electric toothbrush ( )
What else do you use to clean your teeth at home? (Floss, toothpick, water pick, etc.)_____
How often?_____

CONSENT FOR TREATMENT

RISKS OF DENTAL PROCEDURES IN GENERAL: Dr. Justin Braga believes in giving you the best possible dental care. We want you to feel welcome and as comfortable as possible throughout your treatment. This includes understanding your treatment as well as our financial policy.

Included (but not limited to) are complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensations in the lip, tongue, chin, gums, cheeks and teeth, reaction to injections, change in occlusion (biting), muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of teeth or restoration in teeth, injury to other tissues, referred pain to the ear, neck, and head, nausea, vomiting, allergic reactions, itching, bruises, delayed healing, sinus complications and further surgery. Medication prescribed and drugs administered may cause drowsiness and lack of awareness and coordination (which can be influenced by the use of alcohol and other drugs), thus it is advisable not to operate any vehicle or hazardous device, or work until recovered from their effects.

I hereby authorize Dr. Justin Braga, D.D.S., M.S., and whomever he may designate to perform any dental treatment necessary and to administer emergency care as needed. I agree to the use of local anesthetic. I have been informed of possible complications of dental procedures.

I authorize the performance of any laboratory, x-ray or other studies that may be used by Justin Braga, D.D.S., M.S., or his designated staff as deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize Justin Braga, D.D.S., M.S., and his designated staff, to perform all recommended treatment mutually agreed upon by me.

I authorize photos, slides, x-rays, or any other viewings of my care and treatment during or after its completion to be used in the advancement of dentistry through teaching or presentations. My identity will not be revealed to the general public without my permission.

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In order to receive treatment, I contract that if there are any differences or disagreements between Dr. Braga, D.D.S., M.S., and myself, I will first present such differences or disagreements to Dr. Braga in order to resolve the problem. If we are unable to agree on a solution, then I agree to take the problem to a reconciliation board such as the Orange County Dental Society's peer review and agree to accept their

resolution in lieu of pursuing remedies by way of litigation. In consideration of helping to keep costs of treatment and services as low as possible, I also understand that this agreement is binding on my heirs and other family members.

INITIAL:

☐ I understand and agree that I am fully responsible for payment of all services rendered on my behalf or my dependents, regardless of any insurance coverage that I might provide. I understand Dr. Braga's financial policy is that fees are due before or at the time of service. I further understand that unless otherwise coordinated, any balances on my account after 60 days will be assessed a finance charge of 1.25% APR.

☐ I understand that the contract I have with my dental insurance company is between the insurance company and myself, and does not involve Dr. Braga, but if I provide Dr. Braga's office staff with complete information relating to my dental insurance, they will assist me by submitting my claims and interceding on my behalf. I authorize Justin Braga, D.D.S., M.S., and his staff to release information to my insurance company or companies including diagnoses and records of any treatment or examinations rendered. I consent to have payments paid directly to Justin Braga, D.D.S., M.S., from my insurance company. All accounts with an insurance balance over **60 days** will be charged back to myself and I am responsible for the paying the balance. If the office receives additional monies from the insurance company, we will promptly credit your account.

☐ Our office requires 24-hour cancellation notice, or you will be charged $50 per hour of appointment time. This means you must call 24-hours ahead of you appointment time if you wish to cancel, NOT the night before or the morning of your appointment. Please do not wait for us to call and confirm your appointment and then cancel at that time.

We will answer any questions you may have.

Date:_____ Patient / Parent Signature:_____