# ERIC M. PENA, D.D.S., INC.

21830 Nordhoff St. Chatsworth, CA 91311

Phone: (818) 727-7820 || Fax: (818) 727-7101


## Patient Questionnaire

Today's Date: ____________________ Referred By: ____________________

### PATIENT INFORMATION

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr.

Name: ____________________

Address: ____________________

City/State/Zip: ____________________

How long at current address? ____________________

Phone #: ______________ SS #: ______________

Cell #: ____________________

Email: ____________________

Birth Date: ____________ Age: ________ ❑ Male ❑ Female

❑ Single ❑ Married ❑ Widowed

❑ Separated ❑ Divorced ❑ Dependent

### EMPLOYMENT INFORMATION

Employer: ____________________

Work Phone #: ____________________

Occupation: ____________________

How long at current job? ____________________

### RESPONSIBLE PARTY

*IF OTHER THAN PATIENT*

Relationship to patient: ____________________

Name: ____________________

Address: ____________________

City/State/Zip: ____________________

How long at current address? ____________________

Phone #: ______________ SS #: ______________

Cell #: ____________________

Email: ____________________

Birth Date: ____________ Age: ________ ❑ Male ❑ Female

❑ Single ❑ Married ❑ Widowed

❑ Separated ❑ Divorced ❑ Dependent

### INSURANCE

*PPO ONLY, NO HMO, IF NO INS. WRITE NONE*

Insurance Company: ____________________

Address: ____________________

City/State/Zip: ____________________

Phone #: ____________________

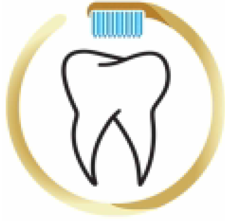
Insured's Employer: ____________________

Insured's Name: ____________________

Relationship to Patient: ____________________

Insured's SS # or Membership #: ____________________

Policy / Group #: ____________________



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## Patient Emergency Information

Name of Patient: ______________________________________________

Name of Emergency Contact: ______________________________________

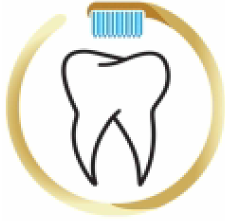
Phone #: ______________________________________________________

Relation to Patient: ____________________________________________

Name of Physician: _____________________________________________

Phone #: ______________________________________________________

EMERGENCY
CONTACTS



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## NOTICE OF PRIVACY PRACTICES
## PATIENT ACKNOWLEDGEMENT

PATIENT NAME: ________________________________

DATE OF BIRTH: ________________________________

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

SIGNATURE: ________________________________________

DATE: ______________________________________________

RELATIONSHIP TO PATIENT: ___________________________
(If signed by personal representative of patient)

## OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _________________ Initials: _________________ Reason: ________________________________

# Medical Questionnaire

Mark your response to indicate if you have had any of the following diseases or problems.
Mark **don't know (DK)**, if you are unsure whether you have had the disease or problem.
If you have a disease or problem that is not listed below, write the disease or condition in the space at the bottom of this form.

| | Yes | No | DK |
|---|---|---|---|
| Do you have tuberculosis? | ❑ | ❑ | ❑ |
| Are you pregnant? | ❑ | ❑ | ❑ |

**Physician -** Name: ______________________________ Phone #: ______________________

Address: ______________________________________________________________

Date of last physical examination: ____________________________

| | Yes | No | DK |
|---|---|---|---|
| Any changes in your health within the past year? | ❑ | ❑ | ❑ |

| **Cardiovascular** | **Yes** | **No** | **DK** |
|---|---|---|---|
| High blood pressure | ❑ | ❑ | ❑ |
| Angina (chest pain) | ❑ | ❑ | ❑ |
| Heart attack | ❑ | ❑ | ❑ |
| Irregular heart beat | ❑ | ❑ | ❑ |
| Heart surgery | ❑ | ❑ | ❑ |
| Heart failure | ❑ | ❑ | ❑ |
| Damaged heart valve | ❑ | ❑ | ❑ |
| High cholesterol | ❑ | ❑ | ❑ |
| Heart infection | ❑ | ❑ | ❑ |
| Stroke | ❑ | ❑ | ❑ |

| **Hematologic** | **Yes** | **No** | **DK** |
|---|---|---|---|
| Anemia | ❑ | ❑ | ❑ |
| Sickle cell anemia | ❑ | ❑ | ❑ |
| Abnormal bleeding | ❑ | ❑ | ❑ |

| **Respiratory** | **Yes** | **No** | **DK** |
|---|---|---|---|
| Asthma | ❑ | ❑ | ❑ |
| Emphysema/Bronchitis | ❑ | ❑ | ❑ |
| Sleep apnea | ❑ | ❑ | ❑ |
| Difficulty breathing | ❑ | ❑ | ❑ |

| **Endocrine** | **Yes** | **No** | **DK** |
|---|---|---|---|
| Diabetes | ❑ | ❑ | ❑ |
| Thyroid problem | ❑ | ❑ | ❑ |

| **Renal** | **Yes** | **No** | **DK** |
|---|---|---|---|
| Kidney Disorder | ❑ | ❑ | ❑ |
| Dialysis | ❑ | ❑ | ❑ |

| **Immune** | **Yes** | **No** | **DK** |
|---|---|---|---|
| Past use of steroids | ❑ | ❑ | ❑ |
| Delayed healing | ❑ | ❑ | ❑ |

| **Musculoskeletal** | **Yes** | **No** | **DK** |
|---|---|---|---|
| Arthritis | ❑ | ❑ | ❑ |
| Artificial joint | ❑ | ❑ | ❑ |
| Fibromyalgia | ❑ | ❑ | ❑ |
| Lupus | ❑ | ❑ | ❑ |
| Sjogren's Syndrome | ❑ | ❑ | ❑ |
| Osteoporosis | ❑ | ❑ | ❑ |

| **Gastrointestinal** | **Yes** | **No** | **DK** |
|---|---|---|---|
| Acid reflux/GERD | ❑ | ❑ | ❑ |
| Irritable bowel syndrome | ❑ | ❑ | ❑ |
| Stomach ulcer | ❑ | ❑ | ❑ |

| **Hepatic** | **Yes** | **No** | **DK** |
|---|---|---|---|
| Liver disease | ❑ | ❑ | ❑ |
| Jaundice | ❑ | ❑ | ❑ |
| Hepatitis | ❑ | ❑ | ❑ |

| **Neurologic** | **Yes** | **No** | **DK** |
|---|---|---|---|
| Epilepsy/Seizures | ❑ | ❑ | ❑ |
| Parkinson's Disease | ❑ | ❑ | ❑ |
| Multiple sclerosis | ❑ | ❑ | ❑ |
| Headaches | ❑ | ❑ | ❑ |

| **Skin** | **Yes** | **No** | **DK** |
|---|---|---|---|
| Hives or skin rash | ❑ | ❑ | ❑ |
| Other skin lesions | ❑ | ❑ | ❑ |

| **Eyes/Ears** | **Yes** | **No** | **DK** |
|---|---|---|---|
| Glaucoma | ❑ | ❑ | ❑ |
| Impaired vision | ❑ | ❑ | ❑ |
| Impaired hearing | ❑ | ❑ | ❑ |

| **Mental Health** | **Yes** | **No** | **DK** |
|---|---|---|---|
| Bipolar disorder | ❑ | ❑ | ❑ |
| Depression | ❑ | ❑ | ❑ |
| Anxiety | ❑ | ❑ | ❑ |
| Eating disorders | ❑ | ❑ | ❑ |
| Sleep disorder | ❑ | ❑ | ❑ |
| Dementia | ❑ | ❑ | ❑ |
| Learning disorders | ❑ | ❑ | ❑ |

| **Infections** | **Yes** | **No** | **DK** |
|---|---|---|---|
| HIV positive / AIDS | ❑ | ❑ | ❑ |
| Sexually transmitted disease | ❑ | ❑ | ❑ |

| **Allergies** | **Yes** | **No** | **DK** |
|---|---|---|---|
| Local anesthetic | ❑ | ❑ | ❑ |
| Antibiotics | ❑ | ❑ | ❑ |
| Aspirin/Ibuprofen | ❑ | ❑ | ❑ |
| Acetaminophen (Tylenol) | ❑ | ❑ | ❑ |
| Codeine/Narcotics | ❑ | ❑ | ❑ |
| Metals | ❑ | ❑ | ❑ |
| Latex | ❑ | ❑ | ❑ |
| Other: _______________ | ❑ | ❑ | ❑ |

| **Other** | **Yes** | **No** | **DK** |
|---|---|---|---|
| Cancer | ❑ | ❑ | ❑ |
| Cancer treatment | ❑ | ❑ | ❑ |
| Nursing infant | ❑ | ❑ | ❑ |
| Tobacco use | ❑ | ❑ | ❑ |
| Alcohol use | ❑ | ❑ | ❑ |
| Chemical dependency | ❑ | ❑ | ❑ |
| Street/recreational/ illicit drug use | ❑ | ❑ | ❑ |

Please list any disease, condition, or problem you have that is not listed above.

______________________________________________________________________________

______________________________________________________________________________

Please list any hospitalizations or surgeries you have had.

______________________________________________________________________________

Medical History Reviewed By:

______________________________ ________________

ERIC M. PENA, D.D.S. DATE

# Dental Information

| | Yes | No |
|---|---|---|
| Is it important for you to keep your teeth? | ❑ | ❑ |
| Are you satisfied with the appearance of your teeth? | ❑ | ❑ |
| Are you satisfied with the function of your teeth? | ❑ | ❑ |
| Does your food frequently get caught between your teeth? | ❑ | ❑ |
| Do your gums often bleed while brushing? | ❑ | ❑ |
| Have you noticed loosening of your teeth? | ❑ | ❑ |
| Have you injured your head, neck, or jaw? | ❑ | ❑ |
| Do you have difficulty eating or swallowing? | ❑ | ❑ |
| Do you have a dry mouth? | ❑ | ❑ |
| Have you had a change in your ability to taste foods? | ❑ | ❑ |

| **Problems of the jaw - Have you noticed:** | Yes | No |
|---|---|---|
| Clicking of the jaw? | ❑ | ❑ |
| Pain (joint, ear, side of face)? | ❑ | ❑ |
| Difficulty opening or closing? | ❑ | ❑ |
| Difficulty chewing? | ❑ | ❑ |

| **Oral habits - Do you:** | Yes | No |
|---|---|---|
| Clench or grind your teeth? | ❑ | ❑ |
| Bite your lips or cheek frequently? | ❑ | ❑ |

| **Have you had:** | Yes | No |
|---|---|---|
| Orthodontic treatment (braces)? | ❑ | ❑ |
| Oral surgery? | ❑ | ❑ |
| Gum treatment? | ❑ | ❑ |
| Your bite adjusted? | ❑ | ❑ |
| A bite plane/guard or other appliance? | ❑ | ❑ |

| **Do you currently have:** | Yes | No |
|---|---|---|
| Dental pain? | ❑ | ❑ |
| Sores or swelling in your mouth? | ❑ | ❑ |
| A partial/full denture or dental implants? | ❑ | ❑ |
| Do you supplement your diet with fluoride? | ❑ | ❑ |
| Have you had any difficulty with dental treatment? | ❑ | ❑ |

Date of last dental x-rays: ____________________

How often do you brush your teeth? ____________________

How often do you floss? ____________________

Date of last dental treatment: ____________________

Date of last teeth cleaning: ____________________

Reason for today's dental visit? ____________________

**Please explain if you answered "Yes" to, or are uncertain about any of the above items.**

____________________

____________________

____________________

____________________

____________________

To the best of my knowledge, the preceding information is complete and correct.

____________________ ____________________

**Signature** - Patient (or parent/guardian if patient is under 18) **Date**

# Medical Updates

I have reviewed my Health History and confirm that it accurately states past and present conditions.

| DATE | PATIENT SIGNATURE | CHANGES TO HEALTH HISTORY | DR. INITIALS |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Medication List

| For patient to fill out (Please list your current medications & past history of use of diet drugs such as (FEN-PHEN) | | | For use by dentist Update section (Enter date of change & new dose of medication. If discontinued, enter D/C) | | |
|---|---|---|---|---|---|
| **Medication and Dose** | **Condition prescribed for** | **MM/YYYY started** | **Date/Change** | **Date/Change** | **Date/Change** |
| | | | | | |
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## AUTHORIZATION

I certify that I, and/or my dependent(s), have insurance with _____________________ and assign directly to

Dr. ___________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_______________________________________ ____________________

**Signature** - Patient, Parent/Guardian, Personal Representative **Date**

# Dental Questionnaire

Correct answers to the following questions will allow us to treat you on a more individual basis, providing the appropriate care for your particular needs. Your answers are for our records only and will be considered CONFIDENTIAL.

1. Are you having any discomfort at this time?
2. Have you ever had any serious trouble associated with previous dentistry?
3. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)?
4. Does dental treatment make you nervous?
5. How often do you brush? ___________________________ Brush is: __________________________
6. Date of last dental visit: ____________________________

**DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?**

| MOUTH | Yes | No |
|---|---|---|
| Bleeding, sore gums | ❑ | ❑ |
| Unpleasant taste/bad breath | ❑ | ❑ |
| Burning tongue/lips | ❑ | ❑ |
| Frequent blisters, lips/mouth | ❑ | ❑ |
| Swelling/lumps in mouth | ❑ | ❑ |
| Ortho treatments (braces) | ❑ | ❑ |
| Biting cheeks/lips | ❑ | ❑ |
| Clicking/popping jaw | ❑ | ❑ |
| Difficulty opening/closing jaw | ❑ | ❑ |

| TEETH | Yes | No |
|---|---|---|
| Loose teeth | ❑ | ❑ |
| Sensitive to hot | ❑ | ❑ |
| Sensitive to cold | ❑ | ❑ |
| Sensitive to sweets | ❑ | ❑ |
| Sensitive when biting | ❑ | ❑ |
| Food impaction | ❑ | ❑ |
| Clenching/grinding | ❑ | ❑ |
| If so, when: ___________________________________ | | |
| Shifting in bite | ❑ | ❑ |
| Change in bite | ❑ | ❑ |

| Do you use the following? | Yes | No |
|---|---|---|
| Toothbrush | ❑ | ❑ |
| Fluoride rinse | ❑ | ❑ |
| Dental floss | ❑ | ❑ |

Other: _____________________________________________

These are the things that are important to me about my dental health: _______________________________________________________________

What do you fear most about dental care? ____________________________________________________________________________________

My mouth is:
❑ very comfortable
❑ moderately comfortable
❑ uncomfortable

I
❑ have set goals for my oral health with my previous dentist
❑ want to set goals now

I
❑ think that the appearance of my mouth is excellent
❑ am satisfied with the appearance of my mouth
❑ am dissatisfied with the appearance of my mouth

I
❑ will do anything to keep my natural teeth
❑ want to keep my teeth but have a certain budget of time and money that I am willing to spend

I
❑ have always done the best that was recommended for my dental health
❑ have not done what dentists have recommended to me
❑ rarely go, and don't care much about having any dental work completed

I
❑ have put dentistry for myself and family high on my priority list
❑ put dentistry for myself and my family low on my priority list
❑ place dentistry on my list but it's hard to find

I think my present state of dental health is: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Do you have any questions about dentistry and oral health that you have never had adequately answered?

_______________________________________________________________________________________________

_______________________________________________________________________________________________

# DENTIST - PATIENT ARBITRATION AGREEMENT

**ARTICLE 1 - Agreement to Arbitrate:** It is understood that any dispute as to dental malpractice, that is as to whether any dental services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to courts process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

**ARTICLE 2 - All Claims must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the Dentist including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of at the small claims court against the Dentist, and the Dentist's partners, associates, association, corporation or partnership, and the employees, agent and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the Dentist to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

**ARTICLE 3 - Procedures and Applicable Law**: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or together expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

**ARTICLE 4 - General Provisions**: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

**ARTICLE 5:** Revocation: This agreement may be revoked by written notice delivered to the Dentist within 30 days of signature. It is the intent of this agreement to apply to all dental services rendered anytime for any condition.

**ARTICLE 6:** Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first dental services.

____________________________________
**Patient's or Patient Representative's Initials**

If any provision of the arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF DENTAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

By: ____________________ ____________ By: ____________________ ____________
**Patient 's Signature** **Date** **Dentist 's Signature** **Date**

____________________ ____________ ____________________ ____________
**Print Patient's Name** **Date** **Print / Stamp Name of Dentist** **Date**