EMPRESA DENTAL
Rancho Santa Margarita

Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you nave any questions or need assistance, please ask us - we will be happy to help.

Patient # _____

SS#/SIN _____

Date _____

Patient Information *(CONFIDENTIAL)*

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/Prov _____ Zip/PC _____

Email _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College _____ City _____ State/Prov _____ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer _____ Work Phone (____)_____

Business Address _____ City _____ State/Prov _____ Zip/PC _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone (____)_____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone (____)_____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to patient _____

Address _____ Home Phone (____)_____

Email _____ Cell Phone (____)_____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone (____)_____ SS#/SIN _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card: ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local# _____ Work Phone (____)_____

Address of Employer _____ City _____ State/Prov _____ Zip/PC _____

Insurance Company _____ Group# _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State/Prov _____ Zip/PC _____

How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local# _____ Work Phone (____)_____

Address of Employer _____ City _____ State/Prov _____ Zip/PC _____

Insurance Company _____ Group# _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State/Prov _____ Zip/PC _____

How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Patient Medical History

Physician_____Office Phone ( )_____Date of Last Exam_____

	Yes	No
1. Are you under medical treatment now?	❑	❑
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	❑	❑
If yes, please explain _____		
3. Are you taking any medication(s) including non-prescription medicine?	❑	❑
If yes, what medication(s) are you taking?_____		
4. Have you ever taken Fen-Phen/Redux?	❑	❑
5. Do you use tobacco?	❑	❑
6. Do you use controlled substances?	❑	❑
7. Are you wearing contact lenses?	❑	❑

9. Are you allergic to or have you had any reactions to the following?

	Yes	No
Local Anesthetics (e.g. Novocain)	❑	❑
Penicillin or any other Antibiotics	❑	❑
Sulfa Drugs	❑	❑
Barbiturates	❑	❑
Sedatives	❑	❑
Iodine	❑	❑
Aspirin	❑	❑
Any Metals (e.g. nickel, mercury, etc.)	❑	❑
Latex Rubber	❑	❑
Other (please list) _____		

10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? ❑ ❑

11. Women Only:

a) Are you pregnant or think you may be pregnant?	❑	❑
b) Are you nursing?	❑	❑
c) Are you taking oral contraceptives?	❑	❑

8. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
Anemia	❑	❑	Frequently Tired	❑	❑	Low Blood Pressure	❑	❑
Angina	❑	❑	Glaucoma	❑	❑	Mitral Valve Prolapse	❑	❑
Arthritis	❑	❑	Hay Fever/Allergies	❑	❑	Radiation Therapy	❑	❑
Asthma	❑	❑	Heart Attack	❑	❑	Recent Weight Loss	❑	❑
AIDS or HIV Infection	❑	❑	Heart Disease	❑	❑	Respiratory Problems	❑	❑
Cancer	❑	❑	Heart Murmur	❑	❑	Rheumatic Fever	❑	❑
Cardiac Pacemaker	❑	❑	Heart Trouble	❑	❑	Sexually Transmitted Disease	❑	❑
Chest Pains	❑	❑	Hepatitis/Jaundice	❑	❑	Stomach Troubles/Ulcers	❑	❑
Diabetes	❑	❑	High Blood Pressure	❑	❑	Stroke	❑	❑
Easily Winded	❑	❑	Joint Replacement or Implant	❑	❑	Swollen Ankles	❑	❑
Emphysema	❑	❑	Kidney Diseases	❑	❑	Thyroid Problem	❑	❑
Epilepsy/Convulsions	❑	❑	Leukemia	❑	❑	Tuberculosis	❑	❑
Fainting/Seizures	❑	❑	Liver-Disease	❑	❑	Other _____	❑	❑

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	❑	❑
2. Are your teeth sensitive to hot or cold liquids/foods?	❑	❑
3. Are your teeth sensitive to sweet or sour liquids/foods ?	❑	❑
4. Do you feel pain to any of your teeth?	❑	❑
5. Do you have any sores or lumps in or near your mouth?	❑	❑
6. Have you had any head, neck or jaw injuries?	❑	❑
7. Have you ever experienced any of the following problems in your jaw?	❑	❑
Clicking	❑	❑
Pain (joint, ear, side of face)	❑	❑
Difficulty in opening or closing	❑	❑
Difficulty in chewing	❑	❑

	Yes	No
8. Do you have frequent headaches?	❑	❑
9. Do you clench or grind your teeth?	❑	❑
10. Do you bite your lips or cheeks frequently?	❑	❑
11. Have you ever had any difficult extractions in the past?	❑	❑
12. Have you ever had any prolonged bleeding following extractions?	❑	❑
13. Have you had any orthodontic treatment?	❑	❑
14. Do you wear dentures or partials?	❑	❑
If yes, date of placement_____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	❑	❑
16. Do you like your smile?	❑	❑

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of patient (or parent/guardian if minor)

Doctor's Comments _____

_____

_____

Signature Date

EMPRESA DENTAL
Rancho Santa Margarita

Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At Empresa Dental, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal health care operations. For example, one of our staff will enter your information in the computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information.

We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine, or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

It this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond me above normal uses.

As we need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the change you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice.

If we change the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Ave, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer at 626) 583-4921.

This notice goes into effect as of April 14, 2005.

ACKNOWLEDGMENT

I have received a copy of Empresa Dental Notice of Privacy Practices. Date _____

Signed _____ Print Name _____

If signing as a parent or guardian, please note the name of the patient _____

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Health Insurance Portability and Accountability Act

Recent legislation has been passed regarding patient's privacy rights and the privacy practices of their health care practioners. We want to assure our patients that we are following the recommendations set forth.
Your privacy is of utmost importance to us. Because we are a "chartless" practice, all of your imformation is stored in our computers, as opposed to being on paper. This makes it easier for us to safeguard our data. No information can be given out without your consent. Under specific conditions, we are permitted to disclose protected health information for federal, state and other health oversight activities, public health activities and emergencies, and/or for judicial and administrative proceedings. We also can disclose any facts to a law enforcement official with a warrant or subpeona.
Most of our insurance claims are sent electronically, and our software is in compliance with the HIPAA Standards for Privacy. Any paper information that we have on our patients, is scanned into the computer and then shredded. No unauthorized persons will be able to access any data.
Should you have any questions regarding data integrity and confidentiality, please feel free to ask; we will be happy to explain it to you.

Consent for Treatment

I grant authority to Empresa Dental to preform procedures and treatment, including, but not limited to, administration of medications, local anesthetics and extractions, along with any other procedures that may be necessary. All procedures, alternate procedures, and possible complications have been fully explained to me. I realize the Treatment Plan information is an estimation of charges; it is subject to modification depending on unforseen or undiagnosable circumstances that may arise during the course of treatment.

I have read the above and understand it.

_____ _____

Patient name Date

EMPRESA DENTAL
Rancho Santa Margarita

Comparisons of Direct Restorative Dental Materials

Types of Direct Restorative Dental Materials

COMPARATIVE FACTORS	AMALGAM	COMPOSITE RESIN (Direct and Indirect Restorations)	GLASS INONOMER CEMENT	RESIN-INONOMER CEMENT
General Description	Self-hardening mixture in varying percentages of a liquid mercury and silver-tin alloy powder.	Mixture of powdered glass and plastic resin; self-hardening or hardened by exposure to blue light.	Self hardening mixture of glass and organic add.	Mixture of glass and resin polymer and organic acid; self hardening by exposure to blue light.
Principal Uses	Fillings; sometimes for replacing portions of broken teeth.	Fillings, Inlays, veneers, partial and complete crowns; sometimes for replacing portions of broken teeth.	Small fillings; cementing metal and porcelain/metal crowns, liners, temporary restorations.	Small fillings; cementing metal and porcelain/metal crowns, and liners.
Resistance to Further Decay	High: self-sealing characteristic helps resist recurrent decay; but recurrent decay around amalgam is difficult to detect RI its early stages	Moderate; recurrent decay is easily detected in early stages.	Low- Moderate; some resistance to decay may be imparted through fluoride release.	Low- Moderate; some resistance to decay may be imparted through fluoride release.
Estimated Durability (permanent teeth)	Durable	Strong, Durable	Non-stress bearing crown cement	Non-stress bearing crown cement
Relative Amount of Tooth Preserved	Fair; Requires removal of healthy tooth to be mechanically retained: No adhesive bond of amalgam to the tooth.	Excellent bonds adhesively to healthy enamel and dentin.	Excellent; bonds adhesively to healthy enamel and dentin.	Excellent; bonds adhesively to healthy enamel and dentin.
Resistance to Surface Wear	Low Similar to dental enamel; brittle metal.	May wear slightly faster than dental enamel.	Poor in stress-bearing applications. Fair in non-stress bearing applications.	Poor in stress-bearing applications; Good in non- stress bearing applications.
Resistance to Fracture	Amalgam may fracture under stress: tooth around filing may fracture before the amalgam does.	Good resistance to fracture.	Brittle; tow resistance to fracture but not recommended for stress" bearing restorations.	Tougher than glass ionomer; recommended for stress-bearing restorations in adults
Resistance to Leakage	Good: self sealing by surface corrosion: margins may chip over time.	Good if bonded to enamel; may show leakage over time when bonded to dentin; Does not corrode.	Moderate: tends to crack overtime.	Good; adhesively bonds to resin, enamel, dentine/post-insertion expansion may help seal the margins.
Resistance to Occlusal Stress	High: but lack of adhesion may weaken the remaining tooth.	Good to Excellent depending upon product used.	Poor: not recommended for stress-bearing restorations.	Moderate: not recommended to restore biting surfaces of adults; suitable for short-term primary teeth restorations.
Toxicity	Generally safe: occasional allergic reactions to metal components. However amalgams contain mercury. Mercury in its elemental form is toxic and as such is listed on prop 65	Concerns about trace chemical release are not supported by research studies. Safe; no known toxicity documented. Contains some compounds listed on prop 65.	No known incompatibilities. Safe; no known toxicity documented.	No known incompatibilities. Safe; no known toxicity documented.
Allergic or Adverse Reactions	Rare: recommend that dentist evaluate patient to rule out metal allergies.	No documentation for allergic reactions was found.	No documentation for allergic: reactions was found. Progressive roughening of the surface may predispose to plaque accumulation and periodontal disease.	No known documented allergic reactions: Surface may roughen to plaque accumulation and periodontal disease if the material contacts the gingival tissue
Susceptibility to post-Operative Sensitivity	Minimal: High thermal conductivity may promote temporary sensitivity to hot and cold; Contact with other metals may cause occasional and transient galvanic response.	Moderate; Material is sensitive to dentist's technique; Material shrinks slightly when hardened. and a poor seal may lead to bacterial leakage, recurrent decay and tooth hypersensitivity.	Low: material seals well and does not irritate pulp.	Low: material seals well and does not irritate pulp.
Esthetics (Appearance)	Very poor. Not tooth colored: Initially silver-gray, gels darker. becoming black as it corrodes. May stain teeth dark brown or black over lime.	Excellent; often indistinguishable From natural tooth.	Good: tooth colored. varies in translucency.	Very good: more translucency than glass ionomer.
Frequency of Repair or Replacement	Low; replacement is usually due to fracture of the filling or the surrounding tooth.	Low-Moderate; durable material hardens rapidly; some composite materials show more rapid wear than amalgam. Replacement is usually due to marginal leakage.	Moderate; slowly dissolves in mouth, easily dislodged.	Moderate; more resistant to dissolving than glass ionomer, but less than composite resin.
Relative Costs to Patient	Low, relatively inexpensive; actual cost of fillings depends upon their size.	Moderate; higher than amalgam fillings; actual cost of fillings depends upon their size; veneers & crowns cost more.	Moderate; similar to composite resin (not used for veneers and crowns)	Moderate; similar to composite resin (not used for veneers and crowns)
Number of Visits Required	Single visit (polishing may require a second visit)	Single visit for fillings; 24 visits for indirect veneers.	Single visit.	Single visit.

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Comparisons of Indirect Restorative Dental Materials

Types of Indirect Restorative Dental Materials

COMPARATIVE FACTORS	PORCELAIN (CERAMIC)	PORCELAIN (FUSED-TO-METAL)	GOLD ALLOYS (NOBLE)	NICKEL OR COBALT-CHROME (BASE-METAL) ALLOYS
General Description	Glass-like material tanned into fillings and crowns using models of the prepared teeth.	Glass-like material that is 'enameled" onto metal shells. Used for crowns and fixed-bridges.	Mixtures of gold, copper and other metals used mainly for crowns and fixed bridges.	Mixtures of nickel, chromium.
Principal uses	Inlay, veneers, crowns and fixed-bridges.	Crowns and fixed-bridges.	Cast crowns and fixed bridges; some partial denture frameworks.	Crowns and Fixed bridges; most partial denture frameworks.
Resistance to Further Decay	Good. if the restoration fits well.	Good. if the restoration fits well.	Good. if the restoration fits well.	Good. if the restoration fits well.
Estimated Durability (permanent teeth)	Brittle material that may fracture under high biting forces. Not recommended for posterior (molar) teeth.	Very good- Less susceptible to fracture due to the metal substructure	Excellent Does not fracture under stress; does not corrode in the mouth.	Excellent. Does not fracture under stress; does not corrode in the mouth.
Relative Amount of Tooth Preserved	Good-Moderate. Little removal of natural tooth is necessary for veneers: more for crowns since strength is related to its bulk.	Moderate-High. More tooth must be removed to permit the metal to accompany the porcelain.	Good. A strong material that requires removal of a thin outside layer of the tooth.	Good. A strong material that requires removal of a thin outside layer of the tooth.
Resistance to Surface Wear	Resistant to surface wear: but abrasive to opposing teeth.	Resistant to surface wear: permits either metal or porcelain on the biting surface of crowns and bridges.	Similar hardness to natural enamel: does not abrade opposing teeth.	Harder than natural enamel but minimally abrasive to opposing natural teeth, does not fracture in bulk.
Resistance to Fracture	Poor resistance to fracture	Porcelain may fracture	Does not fracture in bulk	Does not fracture in bulk
Resistance to Leakage	Very good. Can be fabricated for very accurate fit of the margins of the crowns.	Good -Very good depending upon design of the margins of the crowns.	Very good - Excellent, Can be formed with great precision and can be lightly adapted to the tooth.	Good-Very good - Stiffer than gold: less adaptable, but can be formed with great precision.
Resistance to Occlusal Stress	Moderate: brittle material susceptible to fracture under biting forces.	Very good. Metal substructure gives high resistance to fracture.	Excellent	Excellent
Toxicity	Excellent. No known adverse effects.	Very Good to Excellent Occasional/rare Allergy to metal alloys used.	Excellent; Rare allergy to some alloys.	Good; Nickel allergies are common among women, although rarely manifested in dental restorations.
Allergic or Adverse Reactions	None	Rare. Occasional allergy to metal substructures.	Rare; occasional allergic reactions seen in susceptible individuals.	Occasional: infrequent reactions to nickel.
Susceptibility to Post-Operative Sensitivity	Not material dependent does not conduct heat and cold well.	Not material dependent: dies not conduct heat and cold well.	Conducts heat and cold: may irritate sensitive teeth.	Conducts heat and cold; may irritate sensitive teeth.
Esthetics (Appearance)	Excellent	Good to Excellent	Poor: Yellow Metal	Poor: Dark Silver Metal
Frequency of Repair or Replacement	Vanes: depends upon biting forces; fractures of molar teeth are more likely than anterior teeth; porcelain fracture may often be repaired with composite resin.	Infrequent; porcelain fracture can often be repaired with composite resin.	Infrequent; replacement is usually due to recurrent decay around margins	Infrequent: replacement is usually due to recurrent decay around margins.
Relative Costs to Patient	High: requires at least two office visits and laboratory services.	High; requires at least two office visits and laboratory services.	High; requires at least two office visits and laboratory services.	High; requires at least two office visits and laboratory services
Number of Visits Required	Two-minimum matching esthetics of teeth may require more visits.	Two-minimum: matching esthetics of teeth may require more visits.	Two-minimum	Two-minimum

Patient Acknowledgement of Receipt of Dental Materials Fact Sheet

I, _____ , acknowledge that I have received from _____

patient name

dentist or dental office name

Consent Form for Bleaching

To our patient:

We have had very good success with our in-office bleaching, however, results cannot be guaranteed. Due to the fact that every patient is different, not only genetically, but in their habits, it is impossible for us to guess what your individual outcome will be. Most of our patients have experienced few side effects and/or complications, and have been happy with the end results.

Post-op sensitivity is not unusual, however, it will frequently subside by itself. If it does not, we have options available to help with this.

Teeth whitening is not advised for women who are pregnant.

This treatment is not covered by insurance, as it is considered cosmetic.

We will be sending you home with custom made trays, and a tube of bleach. This will enable you to safely bleach at home to intensify the color, or to use in the future as a maintenance program.

Please be very careful for the first 24 hours with regard to smoking, drinking coffee or cola drinks, and anything else that may stain the teeth.

I have read and understand the above information.

_____ _____

Patient Date

EMPRESA DENTAL
Rancho Santa Margarita

Written Financial Policy

Thank you for choosing Empresa Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

-Cash, Check, Visa, Master Card, Discover Card, American Express.

-NO INTEREST Payment Plans from Care Credit

- **Allow you to pay over time with NO INTEREST**
- **Convenient, low monthly payment plans also available**
- **No annual fees or pre-payment penalties**

Please note:

Empresa Dental requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For patients with dental insurance we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment. If your insurance does not pay within 90 days the balance due will be your responsibility.

A fee of $50 is charged for patients who miss or cancel more than 2 times in a calendar year without 24-hour notice.

Empresa Dental charges $25.00 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you obtain the dentistry you want or need.

_____ _____

Patient, Parent or Guardian Signature **Date**

_____

Patient

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EMPRESA DENTAL
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PATIENT FEEDBACK FORM

Please take a minute to answer these questions. We appreciate your feedback and will use the information to further assist you. Thank you for your time.

1. How has your dental care at this office been going for you?

2. Regarding your care so far, are you:
___very happy with your care
___ satisfied with your care
___ unsatisfied with your care
___ unhappy with your care

3. On a scale of 1 to 10, please rate the front desk receptionist (1 being poor, 10 being excellent)

Friendly___ Helpful___ Knowledgeable___ Professional___ Efficient___

4. On a scale of 1 to 10, please rate the Doctor's assistant

Friendly___ Helpful___ Knowledgeable___ Professional___ Efficient___

5. On a scale of 1 to 10, please rate Dr. Derick Nguy _____ Dr. Trung Ngo _____

Friendly___ Helpful___ Knowledgeable___ Professional___ Efficient___

Caring___ Showing the cause of the pain or problem___ Explaining the treatment___

6. Practice Overall: On a scale of 1 to 10, please rate the following:

Convenient location___ Office parking___ Staff members appearance___

Doctor appearance___ Attractive/comfortable office___

7. Do you have any problems or concerns regarding your care that we have not addressed?