Welcome to South Bay Prosthodontics!

We are delighted to welcome you into our practice and are pleased that you have chosen to entrust us with your dental needs. We provide superior prosthodontic services and are dedicated to creating the best possible experience for our patients. Our goal is to help you look and feel your very best, and to care for you in a way that reinforces your confidence in us and puts you at ease.

In order to facilitate a smooth and timely consultation appointment, we ask that you complete the enclosed Patient Forms before you arrive. In addition to your Patient Forms, please remember to bring with you any insurance cards and communication from a referring doctor.

Please plan to arrive 15 minutes prior to your scheduled appointment time.

If you have any questions prior to your appointment, please feel free to call our office at any time. If you are unable to make your scheduled appointment, please do your best to notify us at least 24 hours in advance. We would be glad to reschedule your appointment at a more convenient time for you if necessary.

Thank you again for choosing South Bay Prosthodontics. We look forward to serving you.

Maria Elena Rodriguez, D.D.S.
Michelle Ikoma, D.D.S.
# PATIENT INFORMATION

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name</td>
<td>First Name</td>
</tr>
</tbody>
</table>

**Birthdate:** ____________  **Sex:** M  F  □Unmarried  □Married  (Spouse’s Name________________________)  
**Address:**________________________  **City:**________________________  **St:**____  **Zip:**__________  
**Preferred Contact Method:** □Mobile  □E-mail  
□Home (____)  □Work (____)  
**May we leave a message?** Y  N  
**Occupation:**________________________  **Employer:**________________________  **Phone:** (____)  
**Contact person in case of emergency:**________________________  **Phone:** (____)  
**Whom may we thank for referring you to our office?**________________________  
**Previous Dentist:**________________________  **City:**________________________  **Phone:** (____)  

# DENTAL INSURANCE

**Primary Insurance Coverage**

<table>
<thead>
<tr>
<th>Carrier Name:</th>
<th>Address:</th>
<th>Group #:</th>
</tr>
</thead>
</table>

**Insured’s Information**

<table>
<thead>
<tr>
<th>Subscriber’s Name:</th>
<th>Employer:</th>
<th>Date of Birth:</th>
<th>Social Security #:</th>
</tr>
</thead>
</table>

**Secondary Insurance Coverage**

<table>
<thead>
<tr>
<th>Carrier Name:</th>
<th>Address:</th>
<th>Group #:</th>
</tr>
</thead>
</table>

**Insured’s Information**

<table>
<thead>
<tr>
<th>Subscriber’s Name:</th>
<th>Employer:</th>
<th>Date of Birth:</th>
<th>Social Security #:</th>
</tr>
</thead>
</table>

# AUTHORIZATION

I AUTHORIZE MY INSURANCE COMPANY TO PAY TO THE DENTIST ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS. I AUTHORIZE THE DENTIST TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY INSURANCE. TREATMENT IS NOT DEPENDENT UPON INSURANCE COVERAGE. WE CANNOT RENDER TREATMENT ON THE ASSUMPTION THAT THE CHARGES WILL BE PAID FOR BY AN INSURANCE COMPANY.

**SIGNATURE:**________________________  **DATE:**________________________

23451 Madison Street  •  Suite 220  •  Building 7  •  Torrance, CA 90505  •  310 378-9261  •  Fax 310-373-5272
### Medical History

**Patient Name**

**Nickname**

**Age**

**Name of Physician/and their specialty**

**Most recent physical examination**

**Purpose**

**What is your estimate of your general health?**

- [ ] Excellent
- [ ] Good
- [ ] Fair
- [ ] Poor

### Do You Have or Have You Ever Had:

1. Hospitalization for illness or injury
2. An allergic reaction to
   - aspirin, ibuprofen, acetaminophen
   - penicillin
   - erythromycin
   - tetracycline
   - codeine
   - local anesthetic
   - fluoride
   - metals (gold, stainless steel)
   - latex
   - any other medications
3. Heart problems
4. Heart murmur
5. Rheumatic fever
6. Scarlet fever
7. High blood pressure
8. Low blood pressure
9. A stroke
10. Artificial prosthesis (i.e. heart valve or joints)
11. Anemia or other blood disorder
12. Prolonged bleeding due to a slight cut
13. Emphysema
14. Tuberculosis
15. Asthma
16. Breathing or sleep problems (i.e. snoring, sinus)
17. Kidney disease
18. Liver disease
19. Jaundice
20. Thyroid or parathyroid disease
21. Hormone deficiency
22. High cholesterol
23. Diabetes
24. Stomach or duodenal ulcer
25. Digestive disorders (i.e. gastric reflux)
26. Osteoporosis/osteopenia (i.e. taking bisphosphonates)
27. Arthritis
28. Glaucoma
29. Contact lenses
30. Head or neck injuries
31. Epilepsy, convulsions (seizures)
32. Neurologic problems
33. Viral infections and cold sores
34. Any lumps or swelling in the mouth
35. HIV, skin rash, hay fever
36. Venereal disease
37. Hepatitis (type ___)
38. HIV / AIDS
39. Tumor, abnormal growth
40. Radiation therapy
41. Chemotherapy
42. Emotional problems
43. Psychiatric treatment
44. Antidepressant medication
45. Alcohol / drug dependency

### Are You:

46. Presently being treated for any other illness
47. Aware of a change in your general health
48. Taking medication for weight management (i.e. fen-phen)
49. Taking dietary supplements
50. Often exhausted or fatigued
51. Subject to frequent headaches
52. A smoker or smoked previously
53. Considered a touchy person
54. Often unhappy or depressed
55. **Female** - taking birth control pills
56. **Female** - pregnant
57. **Male** - prostate disorders

### Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

### List all medications, supplements, and or vitamins taken within the last two years

<table>
<thead>
<tr>
<th>Drug</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Ask for an additional sheet if you are taking more than 6 medications

**Please advise us in the future of any change in your medical history or any medications you may be taking.**

**Patient’s Signature**

**Date**

**Doctor’s Signature**

**Date**

---

2009 Kols Center, LLC

To reorder, please visit: [www.kolscenter.com](http://www.kolscenter.com)
# DENTAL HISTORY

Referrer by __________________________ How would you rate the condition of your mouth? □ Excellent □ Good □ Fair □ Poor

Previous Dentist ________________________ How long have you been a patient? _______ Months/Years

Date of most recent dental exam _______/_____/_______ Date of most recent x-rays _______/_____/_______

Date of most recent treatment (other than a cleaning) _______/_____/_______

I routinely see my dentist every: □ 3 mo. □ 4 mo. □ 6 mo. □ 12 mo. □ Not routinely

**WHAT IS YOUR IMMEDIATE CONCERN?**

**PLEASE ANSWER YES OR NO TO THE FOLLOWING:**

## PERSONAL HISTORY

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are you fearful of dental treatment? Scale of 1 to 10 (very)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Have you had an unfavorable dental experience?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Have you ever had complications from past dental treatment?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Have you ever had trouble getting numb or reactions to local anesthetic?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Did you ever have braces, orthodontic treatment or had your bite adjusted?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Have you had any teeth removed?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## SMILE CHARACTERISTICS

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Is there anything about the appearance of your teeth that you would like to change?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Have you ever whitened (bleached) your teeth?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Are you self-conscious about your teeth?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Have you been disappointed with the appearance of previous dental work?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## BITE AND JAW JOINT

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Do you / would you have any problems chewing gum?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Do you / would you have any problems chewing bagels or other hard foods?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Have your teeth changed in the last 5 years, become shorter, thinner or worn?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Are your teeth crowding or developing spaces?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Do you have more than one bite or do you clench (squeez) to make your teeth fit together?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Do you have any problems with sleep or wake up with an awareness of your teeth?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Do you have tension headaches or sore teeth?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Do you wear or have you ever worn a bite appliance?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## TOOTH STRUCTURE

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>20. Have you had any cavities within the past 3 years?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Do you have a dry mouth?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Are any teeth sensitive to hot, cold, biting or sweets?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Do you avoid brushing any part of your mouth?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Do you feel or notice any holes (i.e. pitting) in your teeth?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## GUM AND BONE

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>26. Have you ever been diagnosed or treated for periodontal (gum) disease?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Have you ever experienced gum recession?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. Is there anyone with a history of periodontal disease in your family?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. Do your gums bleed when brushing, flossing or eating?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. Are your teeth becoming loose?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. Have you ever noticed an unpleasant taste or odor in your mouth?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. Have you experienced a burning sensation in your mouth?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Patient’s Signature ___________________ Date ____________

Doctor’s Signature ___________________ Date ____________
# Latex and/or Iodine Allergy Questionnaire

1. When exposed to latex or rubber, do you suffer runny nose/eyes, wheezing, or shortness of breath?  
   Yes  No

2. Do your hands “break out” within seconds to less than one hour of wearing latex/rubber gloves?  
   Yes  No

3. Do your lips noticeably swell up when you blow up a balloon?  
   Yes  No

4. Have you had unusual swelling after dental procedures, pelvic or rectal exams, vaginal or prostatic ultrasound, barium enema, or condom use which was probably due to the use of latex products?  
   Yes  No

5. Have you ever had multiple surgeries associated with spina bifida or repeated catheterizations with congenital urological defects?  
   Yes  No

6. Do you have respiratory (wheezing, shortness of breath) reactions to tropical or pitted fruits (i.e. bananas, kiwis, chestnuts, avocados, cherries)?  
   Yes  No

7. Are you allergic to iodine?  
   Yes  No

8. Are you allergic to shellfish (i.e. shrimp, crab, lobster)?  
   Yes  No

---

Patient Signature ____________________________ Date __________
E-MAIL CONSENT

We are happy to correspond with you via e-mail, but in order for us to do so, you must provide your consent recognizing that e-mail is not a secure form of communication. There is some risk that any health information and other sensitive or confidential information that may be contained in such e-mail may be misdirected, disclosed to or intercepted by unauthorized third parties.

I consent and accept the risk in receiving information via e-mail.

Patient Signature: _______________________________ Date: ______________

E-mail address _________________________________

CONSENT TO DENTAL PHOTOGRAPHY

I, _________________________________ (Patient), authorize

Dr. Maria Elena Rodriguez, D.D.S., to take photographs, and/or videos of my face, jaws and teeth, before, during and after treatment.

I consent to allow the photographs to be used for the following:

- Dental record
- Dental research, printed materials, patient education
- Dental education including lectures, seminars, demonstrations, professional publications such as journals and books
- Marketing material, including websites and in-office brochures

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential.

☐ Check here if you do not want your full face shot used for any of the above purposes.

Signature (Patient) __________________________ Date ______________

23451 Madison Street • Suite 220 • Building 7 • Torrance, CA 90505 • 310 378-9261 • Fax 310-373-5272
Medicare Private Contract

By signing this contract I understand and agree that I will not submit (or request that my dentist submit) a claim to Medicare or its agents for services provided by MariaElena Rodriguez, D.D.S., or Michelle Ikoma, D.D.S., even if such services would otherwise be covered.

I agree to be fully responsible, through insurance or otherwise, for payment of services rendered by MariaElena Rodriguez, D.D.S., or Michelle Ikoma, D.D.S., and I understand that no claims will be submitted to Medicare and no Medicare reimbursement will be provided for those services.

I understand that there are no limits specified by Medicare as to the amounts that may be charged by the dentist for services provided.

I understand that Medicare plans do not, and other health and medical care insurance plans may elect not to make payments for such services.

I understand that I have the right to have services provided by other dentists or other practitioners for whom Medicare payment would be made, and that I am not compelled to enter into private contracts that apply to covered care furnished by other health care professionals who have not opted-out.

I understand that MariaElena Rodriguez, D.D.S., or Michelle Ikoma, D.D.S., are not excluded from participation in the Medicare program under Section 1128 of the Social Security Act or pursuant to any other legal authority.

This contract is effective on ________________, and it will expire on January 1, 2019.

(Date)

Patient Name: ___________________________ Date: ___________________________

Patient Signature: ___________________________

Dentist’s Signature: ___________________________
INSURANCE INFORMATION

As a courtesy, we will try to assist you in obtaining benefits from your insurance carrier. To assist us, it is very important to bring your current insurance card with you to each visit and to inform us if there has been any change in your coverage or your address.

Please be aware that many surgical procedures which are required to achieve a successful result are not covered. You are ultimately responsible for payment of the full fee for these non-covered procedures. You are also responsible for payment of your co-pay for those procedures which are covered.

While we are happy to submit your treatment plan for pre-authorization of your insurance coverage, we cannot guarantee payment of any specific amount by your insurance carrier. Any balance remaining after insurance becomes the patient’s responsibility to pay in full.

Patient Name: ___________________________ Date: _________________________

Patient Signature: ___________________________
Acknowledgement of Receipt of Dental Materials Fact Sheet and Notice of Privacy Practices

**You May Refuse to Sign this Acknowledgement**

I, __________________________, have received a copy of the SOUTH BAY PROSTHODONTICS Dental Materials Fact Sheet and Notice of Privacy Practices.

Patient Signature: ___________________________ Date: ___________________________

If this Acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Representative’s Name ___________________________ Relationship to Patient ___________________________

For Office Use Only
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign
☐ Communications barriers prohibited obtaining acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other (please specify)
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about your treatment, payment and healthcare options. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: WE may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

23451 Madison Street • Suite 220 • Building 7 • Torrance, CA 90505 • 310 378-9261 • Fax 310-373-5272
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counter intelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

PATIENT RIGHTS
Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. (You must request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.25 for each page, $15 per hour for staff time to locate and copy your health information, and posted if you want copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: if you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. WE will provide you with the address to file a complaint with us or with the U.S. Department of Health and Services.

Contact: Joanna Fernandez
Address: 23451 Madison St., Suite 220, Torrance, CA 90505
Phone: 310-378-9261

23451 Madison Street · Suite 220 · Building 7 · Torrance, CA 90505 · 310 378-9261 · Fax 310-373-5272