

# Paragon Dental

Paragon Dental  
801 Oakdale Rd. Ste. D-5  
Modesto, Ca 95355  
Ph# (209)-548-0100 Fax: (209)-548-0400  
[www.Paragondentalcare.com](http://www.Paragondentalcare.com)

## Thank you for selecting our office!

To help us process your insurance correctly, please fill out this form completely and notify us of any change. We will be happy to help, if any Assistance is required.

### Patient Information:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  Mr.  Mrs.  Ms.  Dr.

I Prefer to be called: \_\_\_\_\_ Email Address: \_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Male  Female Marital Status:  Single  Married Soc. Sec. #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Minor:  Yes  No

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_

In case of Emergency, contact: (Name) \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_ Relationship: \_\_\_\_\_

### Responsible Party Information:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Soc. Sec. #: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_ Ext. \_\_\_\_\_

Name of employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Group/Policy #: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone #: \_\_\_\_\_

### Additional Insurance Information:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Soc. Sec. #: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_ Ext. \_\_\_\_\_

Name of employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Group/Policy #: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone #: \_\_\_\_\_

### Who Can We Thank?

Referred by a friend \_\_\_\_\_  Yellow Pages  1-800-DENTIST  Walk-in  SBC Yellow Pages  Other: \_\_\_\_\_

### Agreement to Pay:

I request that all dental benefits, if any, or other amounts otherwise payable to me or on my behalf for services rendered, be paid directly to the provider of service. I understand that I am financially responsible for all charges for services performed by provider. If insurance proceeds are insufficient to cover my obligations for services rendered, I am liable for the shortfall. I authorize the provider of service to release all information necessary to secure the payment of benefits. I also consent to the examination and/or treatment of myself and all minor children listed by doctors, doctors assistants and other medical personal. Failure to provide complete information may result in receiving a bill for services. I am aware that by signing below I certify that all information is complete and correct. Paragon Dental may verify this information from whichever sources it deems necessary (including, but not limited to, credit reports) and may provide others with information regarding my credit history (or credit report) to the extent permitted by law.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## PARAGON DENTAL/HEALTH HISTORY

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of last health care exam: \_\_\_\_\_ What was this exam for? \_\_\_\_\_

Have you been hospitalized in the last 5 years? (Please circle) No    Yes

If yes, reason: \_\_\_\_\_

Are you currently receiving care? No    Yes    If yes, nature of care: \_\_\_\_\_

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

*For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.*

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Psychosis	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Rheumatic Fever	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS or ARC	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Other Conditions/Tuberculosis	No	Yes
Heart Stent? When placed?	No	Yes	Recurrent Illnesses	No	Yes

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes	Tagamet® (cimetidine) or Prilosec® (omeprazole)?	No	Yes
Antacids?	No	Yes	Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?	No	Yes
Dilantin® or Tegretol®	No	Yes	Serzone® (nefazodone)	No	Yes
Barbiturates (any)	No	Yes	Diflucan® (fluconazole) or Sporonox® (itraconazole)	No	Yes
St. John's Wort or Kava-Kava?	No	Yes	Biaxin® (clarithromycin)	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)? If so, when did the treatment begin?				No	Yes
				When did the treatment end?	
Have you ever taken any prescription drugs such as fen-phen for weight loss?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

Please list any medications you are currently taking and dosages:

- |          |          |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |

Please list any dietary or herbal supplements you are taking, and for what purpose:

1. _____	2. _____
3. _____	4. _____
5. _____	6. _____

<b>Woman:</b> Are you pregnant?	Yes	No	<b>Abnormal Blood Pressure?</b> (please circle)	
Are you a nursing mother?	Yes	No	Have you received a diagnosis of "high blood pressure"?	Yes No
Are you taking birth control pills?	Yes	No	What is your normal blood pressure?	S /D
			Today _____ / _____	

Are you allergic or have you had a reaction to:

- Local anesthetics ..... Yes No
- Penicillin or other antibiotics ..... Yes No
- Aspirin, Ibuprofen or Tylenol ..... Yes No
- Codeine, Valium® or other sedatives..... Yes No
- Latex or Metals..... Yes No
- Other (please specify) \_\_\_\_\_

**Dental History**

What is the reason for today's visit? \_\_\_\_\_

When was your last dental visit? \_\_\_\_\_

How often do you brush? \_\_\_\_\_ Floss? \_\_\_\_\_

- Do your gums bleed when you floss? Yes No
- Do you experience any sensitivity? Yes No
- Have you ever had Orthodontic treatment (braces)? Yes No
- Are you currently experiencing any dental pain? Yes No
- Do you grind your teeth? Yes No
- Do you have any partials or dentures? Yes No
- Have you had any periodontal (gum) treatment? Yes No
- Do you use tobacco? Yes No

Please rate your smile: 1 2 3 4 5 6 7 8 9 10 (best)

Please rate the color of your teeth: 1 2 3 4 5 6 7 8 9 10 (best)

*Here at Paragon Dental we offer a variety of services to enhance your comfort and keep your smile beautiful. Please check any services below you would like us to discuss with you during your visit.*

- Implants
- Sedation
- Bone Grafts
- Veneers
- Nitrous
- Partials/Dentures
- Sealants
- Care Credit
- Root Canals
- Invisalign
- Night Guards
- Wisdom teeth extractions
- In office whitening
- Take home whitening trays
- Crown

**DOCTOR'S USE ONLY**

Comments on patient interview concerning medical history:

Significant findings from questionnaire or oral interview: \_\_\_\_\_

Dental management considerations: \_\_\_\_\_

*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.*

\_\_\_\_\_  
Patient (Print Name)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Doctor Name (Print Name)

\_\_\_\_\_  
Doctor Signature

\_\_\_\_\_  
Date

## Patient Acknowledgment of Receipt of Dental Materials Fact Sheet

I, \_\_\_\_\_, acknowledge I have received from **Paragon Dental** a copy of the Dental Materials Fact Sheet dated 2004.  
Patient name

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

### Comparisons of Indirect Restorative Dental Materials

Comparative Factors	Porcelain (Ceramic)	Porcelain (Fused to Metal)	Gold Alloys (Noble)	Nickel or Cobalt-Chrome (Base Metal) Alloys
<b>General Description</b>	Glass-like material formed 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.
<b>Principal Uses</b>	Inlays, Veneers, Crowns and Fixed-bridges.	Crowns and fixed-bridges.	Cast crowns and fixed bridges; Some partial denture frame works.	Crowns and fixed bridges; most partial denture frameworks.
<b>Resistance to Further Decay</b>	Good, If the restoration fits well.	Good, If the restoration fits well.	Good, If the restoration fits well.	Good, If the restoration fits well.
<b>Estimated Durability (Permanent teeth)</b>	Moderate; 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.
<b>Relative Amount of Tooth Preserved</b>	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.
<b>Resistance to Surface Wear</b>	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.
<b>Resistance to Fracture</b>	Poor resistance to fracture.	Porcelain may fracture.	Does not fracture in bulk.	Does not fracture in bulk.
<b>Resistance to Leakage</b>	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 tightly adapted to the tooth.	Good-very good-Stiffer than gold; less adaptable, but can be formed with great precision.
<b>Resistance to Occlusal Stress</b>	Moderate; brittle material susceptible to fracture under biting forces.	Very good. Metal substructure gives high resistance to fracture.	Excellent	Excellent
<b>Toxicity</b>	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 woman, Although rarely manifested in dental restorations.
<b>Allergic or Adverse Reactions</b>	None	Rare. Occasional allergy to metal substructure.	Rare. Occasional allergic reactions seen in susceptible individuals.	Occasional; infrequent reactions to nickel.
<b>Susceptibility to Post-Operative Sensitivity</b>	Not material dependent; does not conduct heat and cold well.	Not material dependent; does not conduct heat and cold well.	Conducts heat and cold; may irritate sensitive teeth.	Conducts heat and cold; may irritate sensitive teeth.
<b>Esthetics (Appearance)</b>	Excellent	Good to excellent	Poor-yellow metal	Poor-dark silver metal
<b>Frequency of Repair or Replacement</b>	Varies; depends upon biting forced; 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.
<b>Relative Costs to Patient</b>	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.
<b>Number of Visits Required</b>	Two- minimum; matching esthetics of teeth may require more visits.	Two- minimum; matching esthetics of teeth may require more visits.	Two-minimum	Two-minimum