



# PATIENT DENTAL HISTORY

PATIENT'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

REASON FOR THIS VISIT \_\_\_\_\_

WHEN WAS YOUR LAST DENTAL VISIT \_\_\_\_\_ WHAT WAS DONE THEN \_\_\_\_\_

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN \_\_\_\_\_

PREVIOUS DENTIST (NAME AND LOCATION) \_\_\_\_\_

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN WHEN \_\_\_\_\_ WHERE \_\_\_\_\_

HOW OFTEN DO YOU BRUSH YOUR TEETH \_\_\_\_\_ HOW OFTEN DO YOU FLOSS YOUR TEETH \_\_\_\_\_

IS YOUR DRINKING WATER FLUORIDATED \_\_\_\_\_

	YES	NO		YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING .....	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY .	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS .....	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH .....	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS .....	<input type="checkbox"/>	<input type="checkbox"/>	DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH .....	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU FEEL PAIN TO ANY OF YOUR TEETH.....	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS).....	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH .....	<input type="checkbox"/>	<input type="checkbox"/>	EVER WORN A BITE PLATE OR OTHER APPLIANCE. ...	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES.	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST .....	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?			HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS.....	<input type="checkbox"/>	<input type="checkbox"/>
CLICKING .....	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU WEAR DENTURES OR PARTIALS.....	<input type="checkbox"/>	<input type="checkbox"/>
PAIN (JOINT, EAR, SIDE OF FACE) .....	<input type="checkbox"/>	<input type="checkbox"/>	IF YES, DATE OF PLACEMENT _____		
DIFFICULTY IN OPENING OR CLOSING .....	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS .....	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE FREQUENT HEADACHES .....	<input type="checkbox"/>	<input type="checkbox"/>			
DO YOU CLENCH OR GRIND YOUR TEETH.....	<input type="checkbox"/>	<input type="checkbox"/>			

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? \_\_\_\_\_

\_\_\_\_\_

**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 PAYORS 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 \_\_\_\_\_ DATE \_\_\_\_\_  
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

DOCTOR'S COMMENTS \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PATIENT NUMBER \_\_\_\_\_



# PATIENT MEDICAL HISTORY

PATIENT'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

		YES	NO			YES	NO		
1.	ARE YOU IN GOOD HEALTH .....	<input type="checkbox"/>	<input type="checkbox"/>	10.	HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION .....	<input type="checkbox"/>	<input type="checkbox"/>		
2.	HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR .....	<input type="checkbox"/>	<input type="checkbox"/>	11.	HAVE YOU HAD A RECENT WEIGHT LOSS .....	<input type="checkbox"/>	<input type="checkbox"/>		
3.	DATE OF YOUR LAST PHYSICAL EXAM: _____			12.	HAVE YOU EVER TAKEN FEN-PHEN/REDUX .....	<input type="checkbox"/>	<input type="checkbox"/>		
4.	PHYSICIAN'S NAME _____ ADDRESS _____ PHONE NO. _____			13.	DO YOU USE TOBACCO .....	<input type="checkbox"/>	<input type="checkbox"/>		
5.	ARE YOU NOW UNDER THE CARE OF A PHYSICIAN .....	<input type="checkbox"/>	<input type="checkbox"/>	14.	DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES .....	<input type="checkbox"/>	<input type="checkbox"/>		
6.	HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS PLEASE EXPLAIN. _____	<input type="checkbox"/>	<input type="checkbox"/>	15.	ARE YOU WEARING CONTACT LENSES .....	<input type="checkbox"/>	<input type="checkbox"/>		
7.	ARE YOU TAKING ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINE .... IF YES, WHAT MEDICINE(S) ARE YOU TAKING _____	<input type="checkbox"/>	<input type="checkbox"/>	16.	DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS) .....	<input type="checkbox"/>	<input type="checkbox"/>		
8.	HAVE YOU HAD ANY ABNORMAL BLEEDING .....	<input type="checkbox"/>	<input type="checkbox"/>	17.	DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT .....	<input type="checkbox"/>	<input type="checkbox"/>		
9.	DO YOU BRUISE EASILY .....	<input type="checkbox"/>	<input type="checkbox"/>	<b>WOMEN ONLY:</b>					
				ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT .....				<input type="checkbox"/>	<input type="checkbox"/>
				ARE YOU NURSING .....				<input type="checkbox"/>	<input type="checkbox"/>
				ARE YOU TAKING BIRTH CONTROL PILLS .....				<input type="checkbox"/>	<input type="checkbox"/>

		YES	NO			YES	NO
<b>ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:</b>				HIVES OR SKIN RASH .....		<input type="checkbox"/>	<input type="checkbox"/>
	LOCAL ANESTHETICS LIKE NOVOCAINE .....	<input type="checkbox"/>	<input type="checkbox"/>	FADING OR DIZZY SPELLS .....		<input type="checkbox"/>	<input type="checkbox"/>
	PENICILLIN OR OTHER ANTIBIOTICS .....	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES .....		<input type="checkbox"/>	<input type="checkbox"/>
	SULFA DRUGS .....	<input type="checkbox"/>	<input type="checkbox"/>	AIDS OR HIV INFECTION .....		<input type="checkbox"/>	<input type="checkbox"/>
	BARBITURATES, SEDATIVES OR SLEEPING PILLS ..	<input type="checkbox"/>	<input type="checkbox"/>	THYROID PROBLEMS .....		<input type="checkbox"/>	<input type="checkbox"/>
	ASPIRIN .....	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES .....		<input type="checkbox"/>	<input type="checkbox"/>
	IODINE .....	<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS OR RHEUMATISM .....		<input type="checkbox"/>	<input type="checkbox"/>
	ANY METALS (E.G., NICKEL, MERCURY, ETC.) ....	<input type="checkbox"/>	<input type="checkbox"/>	JOINT REPLACEMENT OR IMPLANT .....		<input type="checkbox"/>	<input type="checkbox"/>
	LATEX / RUBBER .....	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH ULCER .....		<input type="checkbox"/>	<input type="checkbox"/>
	OTHER (PLEASE LIST) _____			KIDNEY TROUBLE .....		<input type="checkbox"/>	<input type="checkbox"/>
<b>DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:</b>				TUBERCULOSIS .....		<input type="checkbox"/>	<input type="checkbox"/>
	RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>	PERSISTENT COUGH .....		<input type="checkbox"/>	<input type="checkbox"/>
	SCARLET FEVER .....	<input type="checkbox"/>	<input type="checkbox"/>	COUGH THAT PRODUCES BLOOD .....		<input type="checkbox"/>	<input type="checkbox"/>
	HEART DEFECT OR HEART MURMUR .....	<input type="checkbox"/>	<input type="checkbox"/>	CHEMOTHERAPY (CANCER, LEUKEMIA) .....		<input type="checkbox"/>	<input type="checkbox"/>
	HEART TROUBLE, HEART ATTACK, OR ANGINA ....	<input type="checkbox"/>	<input type="checkbox"/>	SEXUALLY TRANSMITTED DISEASE .....		<input type="checkbox"/>	<input type="checkbox"/>
	CHEST PAIN .....	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY OR SEIZURES .....		<input type="checkbox"/>	<input type="checkbox"/>
	SHORTNESS OF BREATH .....	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA .....		<input type="checkbox"/>	<input type="checkbox"/>
	PACEMAKER .....	<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA .....		<input type="checkbox"/>	<input type="checkbox"/>
	HEART SURGERY .....	<input type="checkbox"/>	<input type="checkbox"/>	NERVOUSNESS .....		<input type="checkbox"/>	<input type="checkbox"/>
	HIGH/LOW BLOOD PRESSURE .....	<input type="checkbox"/>	<input type="checkbox"/>	TONSILLITIS .....		<input type="checkbox"/>	<input type="checkbox"/>
	CONGENITAL HEART PROBLEM .....	<input type="checkbox"/>	<input type="checkbox"/>	TUMORS .....		<input type="checkbox"/>	<input type="checkbox"/>
	SWELLING OF FEET, ANKLES, HANDS .....	<input type="checkbox"/>	<input type="checkbox"/>	MENTAL HEALTH CARE .....		<input type="checkbox"/>	<input type="checkbox"/>
	HEPATITIS, JAUNDICE OR LIVER DISEASE .....	<input type="checkbox"/>	<input type="checkbox"/>	BACK PROBLEMS .....		<input type="checkbox"/>	<input type="checkbox"/>
	STROKE .....	<input type="checkbox"/>	<input type="checkbox"/>	CHEMICAL DEPENDENCY .....		<input type="checkbox"/>	<input type="checkbox"/>
	SINUS TROUBLE .....	<input type="checkbox"/>	<input type="checkbox"/>	MITRAL VALVE PROLAPSE .....		<input type="checkbox"/>	<input type="checkbox"/>
	LUNG OR BREATHING PROBLEMS .....	<input type="checkbox"/>	<input type="checkbox"/>	CORTISONE TREATMENT .....		<input type="checkbox"/>	<input type="checkbox"/>
	ASTHMA OR HAY FEVER .....	<input type="checkbox"/>	<input type="checkbox"/>	COLD SORES/FEVER BLISTERS .....		<input type="checkbox"/>	<input type="checkbox"/>
				HYPOGLYCEMIA .....		<input type="checkbox"/>	<input type="checkbox"/>
				EATING DISORDERS .....		<input type="checkbox"/>	<input type="checkbox"/>

ITEM 07-051677527011

PATIENT NUMBER \_\_\_\_\_



**RIVER OAK DENTAL SPA**  
TOURLOTTE DENTAL CORPORATION  
CHRISTINA TOURLOTTE, DDS  
MARY TOURLOTTE, DDS  
1473 EAST G STREET, SUITE C  
OAKDALE, CA 95361  
(209) 848-8074

## **APPOINTMENT POLICY**

Every effort is made to make appointments for our patients on a timely basis. It is suggested that you arrive five or ten minutes early for your appointment.

Failed appointments without at least 48 hours notice may be subject to a fee up to \$50.00 per hour at the discretion of the office. Patients who are late for their appointment may be rescheduled.

We make every effort to confirm by telephone, every patient's appointments. The responsibility for the appointment, however, is yours and the confirmation process should be viewed as a courtesy.

---

(Signature)

---

(Date)

# River Oak Dental Spa

Christina L. Tourtlotte D.D.S.

Mary C. Tourtlotte D.D.S.

1. All fees and co-payments are due at the time of service. We accept Visa, MC, Discover, Checks, or Cash.
2. Ask us about our convenient payment plans. (Care Credit)
3. Missed Appointment Policy: There will be absolutely no charge for any missed appointments as long as we receive a 48 hour courtesy notice.
4. Emergency treatments are on cash basis and due at the time of service.
5. Parents or guardian must accompany minor children to authorize their care.
6. There may be a \$25.00 fee for all returned checks.
7. Unless prior arrangements are made, ALL balances past 60 days (including any due to insurance delays) will accrue interest and late charges.

## The Insurance Corner:

We accept all insurance plans that allow you the freedom to choose your own dentist. In the best interest of our patients, we choose not to participate in managed care plans. (HMOs)

In most cases, insurance has been a significant factor in people's ability to afford dental care. It is also the most common source of problems and misunderstanding between us and our patients. We make your dental care the focus of our practice, not managing insurance benefits. You are responsible to know your plan benefits and limitations. We can not guarantee insurance payments. We can only assist you with obtaining your benefits by filing claims for you. We DO NOT routinely submit pre-authorizations. If you request a pre-authorization, there will be a \$150 administrative fee that will be credited towards your treatment once you start your care.

## To maximize your Insurance Contributions:

- You must provide us with accurate and current insurance information.
- On your behalf, we submit a claim to your insurance on the date of your service.  
**(This is a courtesy service offered to you at no charge.)**
- If you have had treatment at another dental office, it may affect your eligibility, benefits, and annual maximums. Please inform us of any treatment done within the past 3 years.
- For amounts over \$300.00, ask for written financial agreements.
- Occasionally, insurance companies may send a check directly to you. You must let us know and send us a payment as soon as possible.
- You must be actively involved in all insurance appeals. We will assist.

Since all dental services are provided to YOU, the patient, YOU are ultimately responsible for all fees.

I have read and understand the above policies and have had the opportunity to ask questions and clarify any issues I don't understand.

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

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

# River Oak Dental Spa

Christina L. Tourtlotte D.D.S.

Mary C. Tourtlotte D.D.S.

Name: \_\_\_\_\_

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

*To help us better understand and address your specific oral and dental care needs, please answer the following questions:*

1. **What would prevent you from wanting the absolute very best dental care available today?**
  - A. Fear of pain and anxiety.
  - B. Cost of care, best care means it's expensive.
  - C. I don't have time.
  - D. Can't tolerate long and multiple appointments.
  - E. Nothing, I want the best!
  
2. **In your opinion are all dentists alike?**
  - A. yes
  - B. No
  
3. **How important is the appearance of your teeth and smile? (circle)**  
Extremely Important-----Important-----Not Important
  
4. **How important is the health of your mouth? (circle)**  
Extremely Important-----Important-----Not Important
  
5. **What do you expect and want form your dental care?**
  - A. Right now, looks are more important to me than health.
  - B. I mostly care about health and keeping my teeth for ever.
  - C. I only want treatment when "I" feel I need it.
  - D. Prevention is not important to me. (If it ain't broke, don't fix it!!)
  - E. No one ever dies from having bad teeth. My teeth are not all that important to me.
  - F. You are the doctor. You do what you have to; I want to look great, feel great, be healthy and be able to eat anything. I would like to keep my teeth the rest of my life.
  
6. **How important is your dental insurance policy to you? (circle)**
  - A. I only want treatment that is covered by my insurance.
  - B. I want my insurance plan to dictate my dental treatment needs.
  - C. Insurance companies are interested in my oral and dental health. If they don't pay for a service, then that must meant I didn't need it to begin with!
  - D. I don't want to compromise my dental care; I just want to take full advantage of my benefits. I will pay for any co-pays or fees not covered by my plan for treatments that I need. Just give me an estimate so I know.

**RIVER OAK DENTAL SPA**

**TOURLOTTE DENTAL CORPORATION**

CHRISTINA TOURLOTTE, DDS

MARY TOURLOTTE, DDS

1473 EAST G STREET, SUITE C

OAKDALE, CA 95361

(209) 848-8074

**Patient Acknowledgement of Receipt of: DENTAL MATERIALS SHEET**

I, \_\_\_\_\_, acknowledge that I have received from:

*River Oak Dental Spa  
Dental Office of Tourlotte Corp.  
1473 East G Street, Suite C  
Oakdale, California 95361*

\_\_\_\_\_ a copy of the DENTAL MATERIALS SHEET dated October 2001.

\_\_\_\_\_  
(Patient Signature)

\_\_\_\_\_  
(Date)

The following is the Dental Board of California's Dental Materials Sheet. The Department of Consumer Affairs has no position with the respect to the language of this Dental Material Fact Sheet and it's linkage to the DCA website does not constitute and endorsement of the content of this document.

**RIVER OAK DENTAL SPA**

**TOURLOTTE DENTAL CORPORATION**

**CHRISTINA TOURLOTTE, DDS**

**MARY TOURLOTTE, DDS**

**1473 EAST G STREET, SUITE C**

**OAKDALE, CA 95361**

**(209) 848-8074**

**Joint Notice of Privacy Practices for Health Information (NPP)  
Acknowledgment Form**

Effective April 14, 2003, the law requires that Oak Valley Hospital District give to a patient a copy of its Notice of Privacy Practices for Health Information. We will give you a copy at the time of first treatment and, if we change our notice, thereafter at the next treatment visit. By signing below, you acknowledge receipt's authorized agent, or an individual involved in the patient's medical care.

\_\_\_\_\_  
**(Patient's Name)**

\_\_\_\_\_  
**(Acknowledgment Signature)**

\_\_\_\_\_  
**(Date)**

\_\_\_\_\_  
**(Print Name)**

If signed by someone other than patient

\_\_\_\_\_  
**(Relationship to patient)**