LIBBY DENTAL

www.SanDiegoDentist.net

Hello,

We are so excited to be in this community with you and to have the opportunity to help you and your family and friends with your dental health. If you're looking for a dental home, you just found it. Let us introduce you to our dental office. **Our mission is simple:**

To Inspire Health and Happiness within all of our community. We believe a happy, rich, full life starts with being healthy and feeling pain free.

Our New Patient Experience

A great value to help develop a plan for your health. We start with asking "what's most important to you?" How can we best serve you? Next, a **comprehensive exam,** take **digital X-rays** and use a digital camera to take up-close pictures of your teeth so you can see what we see, and we're all on the same page. Dr Libby will be spending quality time discussing your treatment with you so it makes sense and we can develop a plan together thats customized to fit your health, budget, and time preferences. You will leave our office feeling the support of our team, cheering you on to health.

What we Offer:

Same Day CEREC Crowns using 3D technology

Sedation Dentistry - Snooze while we work, complete relaxation

Dental Implants to replace missing teeth

Cosmetic Dentistry - Veneers, whitening and creating new same-day smiles

Invisalign Orthodontics to straighten your smile

Dental Care for the E**ntire Family**

What makes us different?

I specialize in Knee to Knee conversations to give you what you want and that positive dental experience you've been looking for. We are passionate about **complete health dentistry**, how the health of your mouth is linked to the health of your body. We take care of any urgent needs first and then helping you create your vision for the future for your dental health. Our team is trained to create an experience for you where **you feel valued and understood** and you leave with a detailed plan to keep you healthy. We understand and address the **three biggest roadblocks to dental health. Complimentary Consultations** available to give you the chance to meet us and feel this is a place you want to be.

We can't wait to spend time with you and begin this journey together. Cheers to Health and Happiness!

Dr. Landon Libby and Team

2333 Camino Del Rio S. #310 San Diego CA 92108 **619-276-6884**

ORAL CONSCIOUS SEDATION
PRE-TREATMENT INSTRUCTIONS

LIBBY DENTAL
(619) 276-6884

Oral Sedation is a very safe, simple and effective way for you to be extremely relaxed and even snooze during your dental visit. Early morning visits are recommended because the medicine works best at this time before your body wakes up.

When to take your Medication

- Night before - Pre-Sedation (1 tablet of Triazolam) at bedtime
- Morning Of - Take 2 Ibuprofen Advil, Aleve, Motrin etc. (400mg total)
- At appointment - Bring the rest of your Triazolam prescription with you so Dr Libby can use them to keep you as comfortable as possible.
- After Appointment - We will recommend Post treatment pain medication as needed. Please follow directions as given.

Here is what we found works best:

1. NO eating or drinking after 12:00 midnight the evening prior to your appointment.
2. NO CAFFEINE – remember you want to be as relaxed as possible.
3. Continue your regular medications, unless instructed otherwise.
4. Even if you are extremely nervous, DO NOT DRINK ALCOHOL, before or after your visit, as it will magnify the effect and could be dangerous. Wear loose, comfortable clothing and a short sleeved shirt and a warm long sleeve shirt. We will have a cozy blanket for you.
5. **DO NOT WEAR Contact lenses, jewelry, perfume, etc.**
6. DO NOT DRIVE AT ANY TIME, DO NOT OPERATE MACHINERY OF ANY KIND and NO HEAVY LIFTING for the remainder of the day or evening. You will be fine the following day for all your normal activities.
7. Your driver does *not* have to stay for your visit. We will be happy to call him/her 20-30 minutes before you are done.
8. Plan on relaxing the rest of the day, as each person's response may be different. Do not plan on returning to work or making any important decisions.
9. At the time of pick up, please have your driver park in front of our suite. Even if you feel fine, we will handhold you to your vehicle and buckle you in safely as IT IS OUR OFFICE POLICY.
10. *FOR YOUR SAFETY WE REQUIRE AN ADULT REMAIN WITH YOU ALL DAY.*
11. *Go directly home and please contact our office when you arrive. Drink 24- 32 oz. of water, juice or Gatorade. Soft foods recommended to keep strength up and help healing.*

We promise to do everything in our power to make this a POSITIVE Experience for you!

-Your Team at LIBBY DENTAL

LIBBY DENTAL

Inspiring Health & Happiness

Dr. Landon Libby

2405 Morena Blvd, San Diego CA 92110 • (619) 276-6884 • www.Libby.dental

Please answer all questions on **both** sides, so that we may diagnose your oral health as accurately as possible. All information will be kept strictly confidential. Thank You.

PATIENT'S NAME _____ Preferred Name _____

❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

❑ Male ❑ Female Social Security No. ___ - ___ - ____ Birthdate ___/___/___

Mailing Address _____ Home Phone (___) ___-____

City _____ State _____ Zip Code _____

Cell (___) ___-____ Fax (___) ___-____ Email _____

Whom may we thank for referring you? _____

Name of Spouse _____ Birthdate ___/___/___ Social Security No. ___-___-____

Patient Occupation _____ Employer _____ Work Phone (___) ___-____

Spouse Occupation _____ Employer _____ Work Phone (___) ___-____

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
Employee _____	Employee _____
Employer _____	Employer _____
Insurance Co. _____ Group# _____	Insurance Co. _____ Group# _____
Employee's S.S. No. ___ - ___ - ____	Employee's S.S. No. ___ - ___ - ____

Person responsible for payment: _____

* * * * * *

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name _____ Home Ph. No (___) ___-____ Work Ph. No. (___) ___-____

Relationship to Patient _____

DENTAL HISTORY

Chief dental concern: _____

_____

Are you nervous about having dental treatment? ❑ Yes ❑ No
Have you ever had a bad dental experience? ❑ Yes ❑ No
Do you have difficulty or pain when opening (yawning)? ❑ Yes ❑ No
Does your jaw get stuck, locked or "go out"? ❑ Yes ❑ No
Difficulty / pain when chewing, talking, or using your jaws? Teeth? ❑ Yes ❑ No
Do you have noises in your jaw joints? ❑ Yes ❑ No
Pain about the ears, temples or cheeks? ❑ Yes ❑ No
Does your bite feel uncomfortable or unusual? ❑ Yes ❑ No
Have you had a recent injury to your head / jaw? ❑ Yes ❑ No

Have you been treated for a jaw joint problem? ❑ Yes ❑ No
Do your teeth ever feel loose? ❑ Yes ❑ No
Does food catch in-between your teeth? ❑ Yes ❑ No
How often do you brush?_____ Floss? _____ ❑ Yes ❑ No
Any difficulty chewing your food? ❑ Yes ❑ No
Have you ever had periodontal disease? ❑ Yes ❑ No
Are your teeth sensitive to cold / heat / etc? ❑ Yes ❑ No
Have you ever been premedicated for dental work? ❑ Yes ❑ No
Do you have frequent Headaches? ❑ Yes ❑ No
Are you happy with the way your smile looks? ❑ Yes ❑ No
If not, what would you change? _____

_____

_____

HEALTH HISTORY

Are you having any pain or discomfort at this time? ❑ Yes ❑ No
Do you smoke or use tobacco in any form? ❑ Yes ❑ No
Have you been hospitalized in the past 2 years? ❑ Yes ❑ No
Have you been under the care of a medical doctor during the past 2 years? ❑ Yes ❑ No
Physician Name _____
Address _____ Phone:_____

Are you currently taking any medications / drugs? ❑ Yes ❑ No
If yes, please list: _____
List Medications: _____

_____

_____

_____

Women: Are you pregnant? ❑ Yes ❑ No
Please list any serious medical condition(s) that you have/had:

_____

Please check "Yes or No" to the following conditions:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Angina Pectoris	❑	❑	Sickle Cell Disease	❑	❑	Emphysema / Asthma	❑	❑	Fever Blisters / Cold Sores
❑	❑	Heart Disease / Attack / Stroke	❑	❑	Bruise Easily	❑	❑	Cough / Tuberculosis (TB)	❑	❑	Fainting / Dizzy Spells
❑	❑	Heart Failure	❑	❑	Hemophilia	❑	❑	Arthritis / Rheumatism	❑	❑	Epilepsy / Seizures
❑	❑	High / Low Blood Pressure	❑	❑	Liver Disease / Yellow Jaundice	❑	❑	Cortisone Medicine	❑	❑	Hay Fever / Sinus Trouble
❑	❑	Congenital Heart Defect	❑	❑	Kidney Failure/Disfunction	❑	❑	Venereal Disease	❑	❑	Allergies / Hives
❑	❑	Heart Murmur / Rheumatic Fever	❑	❑	Thyroid Disease	❑	❑	A.I.D.S. / H.I.V.	❑	❑	Shingles
❑	❑	Heart Surgery	❑	❑	Ulcers	❑	❑	Hepatitis: A B C **(circle one)**	❑	❑	Nervousness
❑	❑	Heart Pacemaker	❑	❑	Glaucoma	❑	❑	Frequent Headaches	❑	❑	Psychiatric Treatment
❑	❑	Artificial Heart Valve	❑	❑	Chemotherapy / Cancer	❑	❑	Pain in Jaw Joint	❑	❑	Drug / Alcohol Addiction
❑	❑	Diabetes	❑	❑	X-ray / Cobalt Treatment	❑	❑	Artificial Joints (Hip, Knee)	❑	❑	Blood thinner
❑	❑	Blood Transfusion / Anemia	❑	❑	Cosmetic Surgery	❑	❑	Scarlet Fever	❑	❑	Splenectomy

Are you allergic to or have you reacted adversely to the following?

❑ Antibiotics ❑ Aspirin
❑ Codeine ❑ Latex
❑ Metals / Jewelry ❑ Local/Dental Anesthetic

Are you aware of being allergic to any other medications or substances? If yes, please list:

_____

_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I also give permission to Dr. Landon Libby and his staff to use any photos taken for lecturing and continuing education purposes.

Signature _____ Date _____

Medical History Update
(For Office Use Only)

Date _____ Comments _____ Date _____ Comments _____
Date _____ Comments _____ Date _____ Comments _____
Date _____ Comments _____ Date _____ Comments _____
Date _____ Comments _____ Date _____ Comments _____
Date _____ Comments _____ Date _____ Comments _____

PATIENT FINANCIAL AGREEMENT

Dr. Landon Libby (619) 276 - 6884 www.Libby.dental

PATIENT _____ DATE _____

Thank you for choosing our office for your dental care. Dental treatment is an excellent investment in your medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important, life-enhancing care. We are always available to answer your questions and assist you regarding your treatment needs.

Insurance? We bill and accept payment from most dental insurances. As a courtesy, claims are filed electronically in a timely manner including all information required to receive the maximum benefits *allowed* for the services rendered. Plan details and coverage is between you and the insurance company. As such, we can make no guarantee of estimated coverage or payment.

Estimated Professional Fee $ _____ **NOTES**:

Estimated Insurance Benefit $ _____

Down Payment $ _____

Patient will be billed for any remaining balance due.

Payment Options

- ❑ Plan A: Cash, Check, Debit Card
- ❑ Plan B: Visa, and MasterCard
- ❑ Plan C: Short and long term financing available through CareCredit financing company.
- ❑ Plan D: Upon completion of a Credit Card Authorization Form, we will charge your credit card, as authorized by you.

I have chosen Payment Plan ___ above. I understand that my dental plan/s is strictly a contract between my insurance carrier and myself and that my insurance coverage may vary. As such, I agree to be ultimately responsible for payment of all dental services rendered not paid by insurance within 60 days. Outstanding account balances over 60 days from date of service will accrue one percent (1%) interest per month, ten percent (10%) per year.

_____ _____
Signature of patient or authorized consent Date

_____ _____
Signature of Financial Coordinator Date

Fees quoted will be honored for (*60 days*) days from the date upon which this treatment plan is signed.