Desert Valley
DENTISTRY

Patient's Name: _____
Last First Initial Date of Birth

Consent to share relevant formation

Patient's Signature: _____

Address: _____ Phone: _____

I also give my consent to the following individuals to discuss relevant information and make decisions about my dental care with the Desert Valley Dentistry's staff (continue at the bottom of this page if additional space is needed)

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Witness: _____ Date: _____ Expires: _____

ACKNOWLEDGMENT OF ACCEPTANCE OF PRIVACY PRACTICES NOTICE

Desert Valley
DENTISTRY

PATIENT HISTORY

Medical History

Do you have a primary physician? ☐ Yes ☐ No

Physician's Name _____

Phone # _____

Date of last visit? _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

_____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription/over-the-counter or herbal supplement drugs? ☐ Yes ☐ No

Please list: _____

_____

Have you ever taken Fosamax or any other bisphosphonate?

☐ Yes ☐ No

For women: Are you using a prescribed method of birth control?

☐ Yes ☐ No

Are you pregnant?

☐ Yes, week # _____ ☐ No

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Yes	No		Yes	No	
☐	☐	Abnormal bleeding	☐	☐	Herpes/fever blisters
☐	☐	Alcohol/drug abuse	☐	☐	High blood pressure
☐	☐	Anemia	☐	☐	HIV/AIDS
☐	☐	Arthritis	☐	☐	Hospitalization
☐	☐	Artificial bones/joints/valves	☐	☐	Kidney problems
☐	☐	Asthma	☐	☐	Liver disease
☐	☐	Blood transfusion	☐	☐	Low blood pressure
☐	☐	Cancer/chemotherapy	☐	☐	Mitral valve prolapse
☐	☐	Colitis	☐	☐	Osteoporosis/osteopenia
☐	☐	Congenital heart defect	☐	☐	Pacemaker
☐	☐	Diabetes	☐	☐	Psychiatric treatment
☐	☐	Difficulty breathing	☐	☐	Radiation treatment
☐	☐	Emphysema	☐	☐	Rheumatic/scarlet fever
☐	☐	Epilepsy	☐	☐	Seizures
☐	☐	Fainting spells	☐	☐	Shingles
☐	☐	Frequent headaches	☐	☐	Sickle-cell disease/traits
☐	☐	Glaucoma	☐	☐	Sinus problems
☐	☐	Hay fever	☐	☐	Stroke
☐	☐	Heart attack	☐	☐	Thyroid problems
☐	☐	Heart murmur	☐	☐	Tuberculosis (TB)
☐	☐	Heart surgery	☐	☐	Ulcers
☐	☐	Hemophilia	☐	☐	Venereal disease
☐	☐	Hepatitis			

Medical History

Please list any serious medical condition(s) that you have ever had:

_____

Are you allergic to any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Aspirin	☐	☐	Latex	☐	☐	Sulfa
☐	☐	Anesthetics	☐	☐	Metals			
☐	☐	Erythromycin						
☐	☐	Jewelry	☐	☐	Penicillin			
			☐	☐	Tetracycline			

Please list any other drugs/materials you are allergic to:

_____

Do you have or have you ever had any of the following?

Frequent, heavy snoring	☐ Yes	☐ No
Significant daytime drowsiness	☐ Yes	☐ No
Tendency to stop breathing while sleeping	☐ Yes	☐ No
Shortness of breath when waking up	☐ Yes	☐ No
Not feeling refreshed in the morning after sleep	☐ Yes	☐ No
Morning headaches	☐ Yes	☐ No

Dental History

Why have you come to the dentist today? _____

_____

Do you need antibiotics before dental treatment?	☐ Yes	☐ No	
Are you currently in pain?	☐ Yes	☐ No	
Do your gums ever bleed?	☐ Yes	☐ No	
Have you ever had a serious/difficult problem associated with any previous dental work?	☐ Yes	☐ No	
Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)?	☐ Yes	☐ No	
Your current dental health is:	☐ Good	☐ Fair	☐ Poor
Are you happy with your teeth?	☐ Yes	☐ No	

If not, please tell us why: _____

_____

Would you like whiter teeth?	☐ Yes	☐ No
How many times a week do you floss? _____		
How many times a week do you brush? _____		
Is there anything you have ever wished to be different about your teeth, mouth, or smile?	☐ Yes	☐ No

If so, please describe: _____

_____

Do you use an electric toothbrush?	☐ Yes	☐ No
Do you smoke or use tobacco in any form?	☐ Yes	☐ No

Desert Valley DENTISTRY

PATIENT PROFILE

The benefits of a happy, healthy smile are immeasurable. Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can do for you.

PATIENT INFORMATION

Date _____

Name _____ Email _____

I prefer to be called _____ ☐ Male ☐ Female

Birthday _____ Age _____ SS# _____

Home Address _____

☐ Single ☐ Divorced ☐ Separated

☐ Married ☐ Widowed ☐ Partner

Home Phone # _____ Cell Phone # _____ Work Phone# _____ Ext. _____

Employer _____ Employer Address _____

How long there? _____ Occupation _____

Best time to reach you? _____

Whom may we thank for referring you? _____

Other family member(s) seen by us? _____

Present/previous dentist? _____ Date of last visit? _____

SPOUSE OR PARENT/LEGAL GUARDIAN INFORMATION

Name _____ Date _____

Social Security # _____ Date of Birth _____ Relationship to Patient _____

Home Address _____

Home Phone _____ Cell Phone _____ Work Phone _____ Ext. _____

Employer _____

Email _____

INSURANCE INFORMATION

Insured's Name _____ Insured's ID Number _____

Social Security # _____ Date of Birth _____ Relationship to Patient _____

Employer _____ Occupation _____ # Years Employed _____

Insurance Company _____ Group # _____ Phone # _____

Insurance Company Address _____

Secondary Insurance: _____

Insured's Name _____ Insured's ID Number _____

Social Security # _____ Date of Birth _____ Relationship to Patient _____

Employer _____ Occupation _____ # Years Employed _____

Insurance Company _____ Group # _____ Phone # _____

Insurance Company Address _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

Parent/Guardian Signature _____ Date _____

My relationship to child(ren) is _____, and I have the authority to make financial agreements and consent to treat.

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DENTISTRY

MEDICAL HISTORY

Please answer these questions to the best of your ability. By doing so, you are helping us to find the cause for your health problems as quickly as possible.

HEALTH RELATED QUESTIONS

Your concern: What brought you to us? _____

Do you have an underlying medical disease? ☐ Yes ☐ No If yes, since when, and what was the diagnosis? _____

Acute medical complaints? ☐ Yes ☐ No Where and since when? _____

Acute dental complaints? ☐ Yes ☐ No Where and since when? _____

Dental treatments in the past 3 years? ☐ Yes ☐ No Which? _____

Have you suffered a mental and/or emotional shock in the past 3 years? ☐ Yes ☐ No _____

For women: are you pregnant? ☐ Yes ☐ No If yes, how many months? _____

NUTRITIONAL QUESTIONS

Do you consume sugar and sugary drinks? ☐ Yes ☐ No If yes, which ones and how often/ how much? _____

Do you consume dairy products? ☐ Yes ☐ No If yes, which ones and how often/ how much? _____

Do you eat bread and other cereal/grain products? ☐ Yes ☐ No If yes, which ones and how much? _____

Do you eat meat or sausages? ☐ Yes ☐ No If yes, which ones and how much? _____

LIFESTYLE QUESTIONS

Do you smoke? ☐ Yes ☐ No If yes, how often / how much? _____

Do you consume alcohol? ☐ Yes ☐ No If yes, which products and how often/ how much? _____

How many hours a day do you spend with digital media (TV, computer, smartphone, tablet) on average? _____

Do you use a cell phone or cordless phone at home or at your place of work? ☐ Yes ☐ No _____

Do you make phone calls with your smartphone placed next to your ear? ☐ Yes ☐ No If yes, how many minutes a day? ____

How far is the next cell tower from where you sleep, and since when? _____

Do you have Wi-Fi at home and do you turn it off at night? ☐ Yes ☐ No _____

Do you have Wi-Fi reception from surrounding buildings or apartments? ☐ Yes ☐ No _____

Do you have a demand switch in your apartment / in your house? ☐ Yes ☐ No _____

Do you exercise? ☐ Yes ☐ No If yes, which types of exercise and how often / how much? _____

How many hours do you sleep on average each night? _____

What percentage of your waking hours would you categorise as being stressful? _____

Desert Valley
DENTISTRY

Paitients Name:_____
Last First Initial Date of Birth

FINANCIAL ARRANGEMENT GUIDELINES

Payment Options: Cash, Check, Debit or Credit Card. (MasterCard, Visa, American Express, Discover, Care Credit)

Insurance:

* As a courtesy to you, we will bill your Insurance for you. Please help us by providing the current and correct information needed regarding your dental insurance including the name of your insurance company, policy number, personal ID number, phone, address and your child/children's name(s), date of birth, and ID number if appropriate.

* Deductable and Patient Portion of the cost of the visits are due at the time of service. Any patient portion not paid on date of service must have arrangements made prior to visit.

* If your Insurance/Medicaid or other Institution fails to honor our request for payment, youare ultimately responsible for any unpaid balance.

* We ask that you present all Insurance/Medicaid before your visit.

* Please remember that we can only provide you with an estimate of the patient portion of treatment fees. This this is never a guarantee of payment.

Billing Fee: All account balances of over 30 days will be charged interest at the rate of 21% per annum.

I, the undersigned client, agree to pay for all services rendered and/or goods sold to me immediately upon demand. I further agree that in the event of nonayment of any amounts due under the agreement, I will pay interest thereonat the rate of 1.75% per month and pay all reasonable attorney fees and court costs that may be incurred. I agree that in the event this agreement is assigned to an agency for collections, I promise to pay an additional collection fee of 35% of the unpaid balance due.

Missed Appointments: As a courtesy please call our office 24 hours in advance if you are not able to keep an appointment.

I have read and agree to abide by the Desert Valley Dentistry Financial Policy

Patient Signature:_____ Date_____