

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)

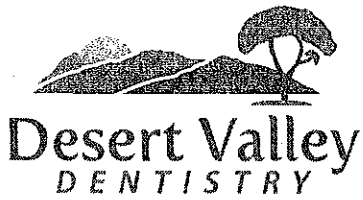
Name: \_\_\_\_\_ Relation: \_\_\_\_\_

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

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

Witness: \_\_\_\_\_ Date: \_\_\_\_\_ Expires: \_\_\_\_\_

### ACKNOWLEDGMENT OF ACCEPTANCE OF PRIVACY PRACTICES NOTICE



## 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   |
|--|--|
| <input type="checkbox"/> <input type="checkbox"/> Abnormal bleeding              | <input type="checkbox"/> <input type="checkbox"/> Herpes/fever blisters      |
| <input type="checkbox"/> <input type="checkbox"/> Alcohol/drug abuse             | <input type="checkbox"/> <input type="checkbox"/> High blood pressure        |
| <input type="checkbox"/> <input type="checkbox"/> Anemia                         | <input type="checkbox"/> <input type="checkbox"/> HIV/AIDS                   |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis                      | <input type="checkbox"/> <input type="checkbox"/> Hospitalization            |
| <input type="checkbox"/> <input type="checkbox"/> Artificial bones/joints/valves | <input type="checkbox"/> <input type="checkbox"/> Kidney problems            |
| <input type="checkbox"/> <input type="checkbox"/> Asthma                         | <input type="checkbox"/> <input type="checkbox"/> Liver disease              |
| <input type="checkbox"/> <input type="checkbox"/> Blood transfusion              | <input type="checkbox"/> <input type="checkbox"/> Low blood pressure         |
| <input type="checkbox"/> <input type="checkbox"/> Cancer/chemotherapy            | <input type="checkbox"/> <input type="checkbox"/> Mitral valve prolapse      |
| <input type="checkbox"/> <input type="checkbox"/> Colitis                        | <input type="checkbox"/> <input type="checkbox"/> Osteoporosis/osteopenia    |
| <input type="checkbox"/> <input type="checkbox"/> Congenital heart defect        | <input type="checkbox"/> <input type="checkbox"/> Pacemaker                  |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes                       | <input type="checkbox"/> <input type="checkbox"/> Psychiatric treatment      |
| <input type="checkbox"/> <input type="checkbox"/> Difficulty breathing           | <input type="checkbox"/> <input type="checkbox"/> Radiation treatment        |
| <input type="checkbox"/> <input type="checkbox"/> Emphysema                      | <input type="checkbox"/> <input type="checkbox"/> Rheumatic/scarlet fever    |
| <input type="checkbox"/> <input type="checkbox"/> Epilepsy                       | <input type="checkbox"/> <input type="checkbox"/> Seizures                   |
| <input type="checkbox"/> <input type="checkbox"/> Fainting spells                | <input type="checkbox"/> <input type="checkbox"/> Shingles                   |
| <input type="checkbox"/> <input type="checkbox"/> Frequent headaches             | <input type="checkbox"/> <input type="checkbox"/> Sickle-cell disease/traits |
| <input type="checkbox"/> <input type="checkbox"/> Glaucoma                       | <input type="checkbox"/> <input type="checkbox"/> Sinus problems             |
| <input type="checkbox"/> <input type="checkbox"/> Hay fever                      | <input type="checkbox"/> <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> <input type="checkbox"/> Heart attack                   | <input type="checkbox"/> <input type="checkbox"/> Thyroid problems           |
| <input type="checkbox"/> <input type="checkbox"/> Heart murmur                   | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis (TB)          |
| <input type="checkbox"/> <input type="checkbox"/> Heart surgery                  | <input type="checkbox"/> <input type="checkbox"/> Ulcers                     |
| <input type="checkbox"/> <input type="checkbox"/> Hemophilia                     | <input type="checkbox"/> <input type="checkbox"/> Venereal disease           |
| <input type="checkbox"/> <input type="checkbox"/> Hepatitis                      |  |

## PATIENT HISTORY

### Medical History

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

Are you allergic to any of the following?

- |  |  |   |
|--|--|---|
| Yes No   | <input type="checkbox"/> <input type="checkbox"/> Latex        | <input type="checkbox"/> <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> <input type="checkbox"/> Aspirin      | <input type="checkbox"/> <input type="checkbox"/> Metals       |   |
| <input type="checkbox"/> <input type="checkbox"/> Anesthetics  |  |   |
| Yes No   | <input type="checkbox"/> <input type="checkbox"/> Penicillin   |   |
| <input type="checkbox"/> <input type="checkbox"/> Erythromycin | <input type="checkbox"/> <input type="checkbox"/> Tetracycline |   |
| Yes No   |  |   |
| <input type="checkbox"/> <input type="checkbox"/> Jewelry      |  |   |

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                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Significant daytime drowsiness                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Tendency to stop breathing while sleeping        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Shortness of breath when waking up               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Not feeling refreshed in the morning after sleep | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Morning headaches                                | <input type="checkbox"/> Yes <input type="checkbox"/> 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



## 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 _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Birthday _____	Age _____ SS# _____
Home Address _____	
<input type="checkbox"/> Single	<input type="checkbox"/> Divorced <input type="checkbox"/> Separated
<input type="checkbox"/> Married	<input type="checkbox"/> Widowed <input type="checkbox"/> 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

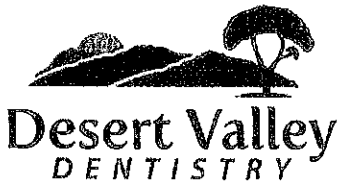
Insured's Name _____	Insured's ID Number _____
Social Security # _____	Date of Birth _____ Relationship to Patient _____
Employer _____	Occupation _____ # Years Employed _____
Insurance Company _____	Group # _____ Phone # _____
Insurance Company Address _____	
Secondary Insurance: _____	
Insured's Name _____	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.



## 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? \_\_\_\_\_



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## 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, you are 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 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 nonpayment of any amounts due under the agreement, I will pay interest thereon at 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 \_\_\_\_\_