

Welcome

THANK YOU FOR GIVING US THE OPPORTUNITY
TO SERVE YOUR DENTAL NEEDS. PLEASE FILL
OUT THIS FORM COMPLETELY.

NAME: _____
LAST FIRST MI

MALE
 FEMALE

I PREFER TO BE CALLED: _____

BIRTHDATE ____/____/____ SS#: _____

EMAIL: _____

HOME ADDRESS: _____
STREET APT NO.

CITY STATE ZIP

SINGLE MARRIED DIVORCED WIDOWED SEPARATED

HOME # (____) _____ CELL # (____) _____

WORK # (____) _____ DRIVER LIC # _____

FULL TIME STUDENT? NO YES -- SCHOOL ATTENDING: _____

EMPLOYER: _____

EMPLOYER'S ADDRESS _____
STREET SUITE

CITY STATE ZIP

HOW LONG THERE? _____ OCCUPATION _____

WHERE & WHEN ARE BEST TIMES TO REACH YOU? _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

OTHER FAMILY MEMBERS SEEN BY US: _____

SPOUSE'S NAME: _____

EMPLOYER: _____

WORK # (____) _____ SS#: _____

BIRTHDATE: ____/____/____ DRIVER LIC # _____

PERSON RESPONSIBLE FOR ACCOUNT: PATIENT SPOUSE

OTHER: _____

WORK # (____) _____ HOME # (____) _____

BILLING ADDRESS _____
STREET APT #

CITY STATE ZIP

RELATION: _____ SS#: _____

BIRTHDATE: ____/____/____ DRIVER LIC #: _____

EMPLOYER: _____

TODAY'S DATE ____/____/____

PRIMARY DENTAL INSURANCE

INSURANCE CO. NAME: _____

INSURANCE CO. ADDRESS: _____

INSURANCE CO. PHONE # (____) _____

GROUP # (PLAN, LOCAL OR POLICY#) _____

INSURED'S NAME: _____ RELATION: _____

INSURED'S BIRTHDATE: ____/____/____ INSURED ID# _____

INSURED'S EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

SECONDARY DENTAL INSURANCE

INSURANCE CO. NAME: _____

INSURANCE CO. ADDRESS: _____

INSURANCE CO. PHONE # (____) _____

GROUP # (PLAN, LOCAL OR POLICY#) _____

INSURED'S NAME: _____ RELATION: _____

INSURED'S BIRTHDATE: ____/____/____ INSURED ID# _____

INSURED'S EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

IN THE EVENT OF AN EMERGENCY, IS THERE SOMEONE
WHO LIVES NEAR YOU THAT WE SHOULD CONTACT?

NAME: _____ REALTION: _____

WORK # (____) _____ HOME # (____) _____

MEDICAL HISTORY

PHYSICIAN'S NAME: _____

WORK # (____) _____ DATE OF LAST VISIT _____

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? YES NO

PLEASE EXPLAIN: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS? (PLEASE CIRCLE THE OPTION THAT APPLIES)

- | | | | | | |
|-----|----|--------------------------|-----|----|-------------------------|
| YES | NO | ABNORMAL BLEEDING | YES | NO | HIV+ OR AIDS |
| YES | NO | ALCOHOL ABUSE | YES | NO | HEART ATTACK |
| YES | NO | ALLERGIES | YES | NO | HEART DISEASE |
| YES | NO | ANEMIA | YES | NO | HEPATITIS |
| YES | NO | ANGINA PECTORIS | YES | NO | HIGH BLOOD PRESSURE |
| YES | NO | ARTHRITIS | YES | NO | INJURY TO HEAD OR FACE |
| YES | NO | ARTIFICIAL HEART | YES | NO | KIDNEY PROBLEMS |
| YES | NO | ARTIFICIAL JOINTS | YES | NO | LIVER DISEASE |
| YES | NO | ASTHMA | YES | NO | LOW BLOOD PRESSURE |
| YES | NO | BLOOD DISEASE | YES | NO | MITRAL VALVE PROLAPSE |
| YES | NO | BREATHING PROBLEMS | YES | NO | PACEMAKER |
| YES | NO | CANCER-CHEMOTHERAPY | YES | NO | PSYCHIATRIC PROBLEMS |
| YES | NO | CIRCULATORY PROBLEMS | YES | NO | RADIATION THERAPY |
| YES | NO | COLITIS | YES | NO | RHEUMATIC FEVER |
| YES | NO | CONGENITAL HEART DISEASE | YES | NO | SEIZURES |
| YES | NO | COSMETIC SURGERY | YES | NO | SEXUALLY TRANS. DISEASE |
| YES | NO | DIABETES | YES | NO | SINUS PROBLEMS |
| YES | NO | DRUG ABUSE | YES | NO | SLEEP APNEA |
| YES | NO | EMPHYSEMA | YES | NO | STROKE |
| YES | NO | EPILEPSY | YES | NO | THYROID PROBLEMS |
| YES | NO | FAINTING SPELLS | YES | NO | TUBERCULOSIS |
| YES | NO | GASTROESOPHOGEAL REFLUX | YES | NO | ULCERS |
| YES | NO | GLAUCOMA | | | |

PLEASE LIST ANY SERIOUS MEDICAL CONDITIONS THAT YOU HAVE EVER HAD OR EXPLAIN ANY "YES" ANSWERS FROM THE LIST ABOVE: _____

ARE YOU ALLERGIC OR HAD AN ADVERSE REACTION TO ANY OF THE FOLLOWING?

- | | | | | | |
|-----|----|--------------------|-----|----|------------------|
| YES | NO | ASPIRIN | YES | NO | JEWELRY / METALS |
| YES | NO | CODEINE | YES | NO | LATEX |
| YES | NO | DENTAL ANESTHETICS | YES | NO | PENICILLIN |
| YES | NO | ERYTHROMYCIN | YES | NO | TETRACYCLINE |

PLEASE LIST ANY OTHER DRUGS OR MATERIALS THAT YOU ARE ALLERGIC OR HAVE HAD AN ADVERSE REACTION TO: _____

ARE YOU TAKING ANY PRESCRIPTION DRUG, OVER-THE-COUNTER MEDICATION, OR SUPPLEMENT?

PLEASE LIST EACH ONE: _____

YES NO FEMALES: ARE YOU PREGNANT? IF SO, HOW MANY WEEKS: _____

YES NO FEMALES: ARE YOU NURSING?

YOUR CURRENT PHYSICAL HEALTH IS (PLEASE CIRCLE): GOOD FAIR POOR

YES NO HAS A PHYSICIAN RECOMMENDED THAT YOU NEED TO TAKE ANTIBIOTICS BEFORE DENTAL TREATMENT?

YES NO DO YOU SMOKE OR USE TOBACCO IN ANY OTHER FORM?

YES NO HAVE YOU EVER TAKEN FOSAMAX OR ANY OTHER BISPHTHONATE?

YES NO DO YOU USE CPAP OR HAVE EVER TRIED TO USE CPAP?

YES NO DO YOU SNORE?

YES NO DO YOU HAVE HIGH BLOOD PRESSURE?

YES NO HAS ANYONE REPORTED THAT YOU CHOKED OR GASP FOR AIR WHILE SLEEPING?

WHAT IS YOUR NECK SIZE (IN INCHES)? _____

YES NO DO YOU AWAKE REFRESHED?

YES NO ARE YOU EXCESSIVELY TIRED DURING THE DAY?

YES NO DO YOU GET HEADACHES? IF SO, PLEASE ANSWER THE NEXT 6 QUESTIONS

HOW OFTEN? _____

HAS THERE BEEN A CHANGE IN YOUR HEADACHE PATTERN? _____

DOES ANYTHING TRIGGER YOUR HEADACHES? _____

TO WHAT DEGREE WOULD YOU SAY YOUR HEADACHES EFFECT YOUR LIFE? _____

ON A SCALE OF ONE (LEAST) TO TEN (WORST), WHAT IS THE RANGE OF YOUR HEADACHES? _____

HAVE YOU BEEN TREATED OR EVALUATED FOR YOUR HEADACHES? _____

DENTAL HISTORY

HOW WOULD YOU RATE YOUR CURRENT DENTAL HEALTH? GOOD FAIR POOR

DATE OF YOUR LAST DENTAL VISIT: _____

WHY HAVE YOU COME TO THE DENTIST TODAY? _____

YES NO ARE YOU CURRENTLY IN PAIN?

YES NO DO YOUR GUMS EVER BLEED?

YES NO ARE YOUR TEETH SENSITIVE TO HOT, COLD, OR CHEWING?

YES NO HAVE ANY COMPLICATION WITH ANY PREVIOUS DENTAL WORK?

YES NO HAVE YOU EVER HAD ANY HEAD, NECK, OR JAW INJURY?

YES NO EVER HAD ORTHODONTIC TREATMENT (BRACES)?

YES NO EVER HAD ANY ORAL SURGERY?

YES NO EVER HAD ANY PERIODONTAL (GUM) TREATMENT?

YES NO EVER WEAR ANY FULL OR PARTIAL DENTURE?

YES NO EVER HAD ANY DENTAL IMPLANTS?

YES NO ARE YOU AWARE IF YOU CLENCH OR GRIND YOUR TEETH?

YES NO ARE YOU PRESENTLY AWARE OF JOINT SOUNDS?

YES NO DID YOU EVER HAVE JOINT SOUNDS?

YES NO DO YOU EVER HAVE PAIN OR SORENESS IN FRONT OF YOUR EARS?

YES NO DO YOU HAVE EAR PAIN?

YES NO DO YOU WAKE UP WITH YOUR JAWS SORE OR TIRED?

YES NO DO YOU EVER HAVE DIFFICULTY OPENING WIDELY?

YES NO DO YOU AVOID EATING CERTAIN FOODS BECAUSE OF DISCOMFORT?

YES NO HAVE YOU EVER WORN A BITEGUARD, SPLINT, OR NIGHTGUARD?

YES NO WOULD YOU LIKE TO CHANGE ANYTHING ABOUT YOUR SMILE?

IF SO, PLEASE EXPLAIN: _____

HOW MANY TIMES A DAY DO YOU BRUSH YOUR TEETH? _____

HOW MANY TIMES A WEEK DO YOU FLOSS? _____

IS THERE ANYTHING ELSE YOU WANT US TO KNOW ABOUT YOUR MEDICAL AND DENTAL HEALTH? _____

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 AUTHORIZE THE DENTAL STAFF TO PERFORM ANY NECESSARY DENTAL SERVICES THAT I MAY NEED DURING DIAGNOSIS AND TREATMENT WITH MY INFORMED CONSENT.

SIGNATURE _____

DATE _____

Office Policy

In order to serve you better, please be aware of the following office policies:

It is mandatory to have a copy of your driver's license or other government-issued identification and any insurance cards. Please present them when you check in at your first visit, we will copy the cards and return them to you.

All fees, insurance deductibles, and/or insurance co-payments are due at the time of service unless prior arrangements have been made with the office management.

We offer to bill your insurance carrier for you as long as we have complete billing information and your signature on file. Therefore, your signature below acknowledges the following:

- you assign directly to Arrowhead Lakes Dentistry, PC all insurance benefits otherwise payable to you,
- you understand that you are responsible for payment of services rendered,
- you understand that you are responsible for paying any co-payment and deductible that your insurance does not cover,
- you authorize Arrowhead Lakes Dentistry, PC to release all information necessary to secure the payment of benefits, and
- you authorize the use of this signature on all your insurance submissions, whether manual or electronic.

It is important to know that regardless of your insurance coverage, all fees are ultimately your responsibility. We attempt to provide for you accurate estimates of insurance benefits: however, you are responsible for all treatment fees regardless the accuracy of our estimates or the estimates of the insurance company.

Any unpaid balances over 90 days old will incur a finance charge of 1.50% per month. A \$25.00 fee is charged for all returned checks. Any collection and/or legal fees will be your responsibility. Costs of collection include, without limitation, all fees charged by a collection agency as well as attorney's fees, small claims court costs, and any other expenses incurred in an effort to collect the account. When appropriate, credit bureau reports may be obtained.

Please notify us if a full set of dental xrays or a panoramic xray have been taken within the last 3 years. Most insurance companies will not pay for another set within a 3 to 5 year period. Since your authorization would be necessary, it is your responsibility to obtain readable xrays from previous dental offices. Our office does not use the amalgam (silver) fillings. We provide the composite resin, tooth-colored fillings. Some insurance companies will only allow a percentage payment towards the silver.

We will try to reach you the day before your appointment to confirm the appointment. However, the confirmation is a courtesy and you are responsible to keep your appointment whether or not you were contacted. Please cancel any appointment 24 hours prior to the appointment. There is a \$30.00 per hour charge for all missed dental appointments without 24 hours notice of cancellation.

Signature

Date