WELCOME

Patient Information

Date_____

Patient Name _____
Last Name Middle Initial
_____
First Name

Sex ☐ M ☐ F

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Date of Birth: _____

SS#: _____

Address_____

City _____

State _____ Zip_____

E-mail _____

Home (____)_____

Work (____)_____Ext._____

Cell Phone (____)_____

Best time and place to reach you_____

Occupation_____

Patient Employer/School_____

Employer/School Phone (____)_____

Spouse (Parent/Guardian) Name_____

Spouse's Work (____)_____

Birthdate_____ SS#_____

Dental Insurance

Who is responsible for this account?_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Primary Insurance:

Subscriber's Name_____

Date Of Birth_____ SS/Patient ID#:_____

Relationship to Patient_____

Employer_____

Insurance Co. _____

Insurance Phone(____)_____

Group #_____

Secondary Insurance:

Subscriber's Name_____

Date Of Birth_____ SS/Patient ID#: _____

Relationship to Patient_____

Employer_____

Insurance Co._____

Insurance Phone(____)_____

Group #_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to Canyon Vista Dental Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dental office, Canyon Vista Dental Care, may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Relationship to Patient Date

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name_____

Relationship_____

Home Phone (____)_____

Work Phone (____)_____

Health History

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Are you currently taking prescription bisphosphonates, (Fosomax, Zometa, Aredia, Pamisol, etc.) for increased bone density? ☐ Y ☐ N

Pre-med	☐ Y ☐ N	Heart Murmur	☐ Y ☐ N	Respiratory Problems	☐ Y ☐ N
AIDS/HIV	☐ Y ☐ N	Heart Problems	☐ Y ☐ N	Rheumatic Fever	☐ Y ☐ N
Allergies _____		Hepatitis Type_____	☐ Y ☐ N	Rheumatism	☐ Y ☐ N
_____	☐ Y ☐ N	Herpes	☐ Y ☐ N	Sinus Problems	☐ Y ☐ N
Artificial Joints	☐ Y ☐ N	High Blood Pressure	☐ Y ☐ N	Stints	☐ Y ☐ N
Asthma	☐ Y ☐ N	Kidney Disease	☐ Y ☐ N	Stomach Problems	☐ Y ☐ N
Blood Thinner	☐ Y ☐ N	Latex Allergy	☐ Y ☐ N	Stroke	☐ Y ☐ N
Cancer	☐ Y ☐ N	Liver Disease	☐ Y ☐ N	Thyroid Problems	☐ Y ☐ N
Diabetes	☐ Y ☐ N	Low Blood Pressure	☐ Y ☐ N	Tuberculosis	☐ Y ☐ N
Emphysema	☐ Y ☐ N	Mental Disorders	☐ Y ☐ N	Tumor or growths	☐ Y ☐ N
Epilepsy	☐ Y ☐ N	Mitral Valve Prolapse	☐ Y ☐ N	Prosthetics	☐ Y ☐ N
Glaucoma	☐ Y ☐ N	Nervous Disorders	☐ Y ☐ N	Tobacco use_____	☐ Y ☐ N
Heart Disease	☐ Y ☐ N	Pacemaker	☐ Y ☐ N	For how long?_____	
		Radiation Treatment	☐ Y ☐ N		

Please Explain any of the above: _____

Women:

Are you pregnant? ☐ Y ☐ N Due date_____ Are you nursing? ☐ Y ☐ N

Taking birth control pills? ☐ Y ☐ N Hormone Replacement? ☐ Y ☐ N

Please list any current medications: ☐ Please check if you have a list (we will be happy to make a copy for our records).

Medication:	Ailment medication is for:
_____	_____
_____	_____
_____	_____
_____	_____

Have you been admitted to a hospital or received emergency care in the last two years? ☐ Y ☐ N

If yes, please explain: _____

Name of primary care physician:_____ Date of last examination:_____

Phone (____)_____

Are you currently under treatment? If yes, please explain: _____

Please list any other medical conditions not listed above: _____

Dental History

Reason for today's visit_____

_____

Former Dentist_____

Phone (____)_____

City/State_____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath ☐ Y ☐ N

Bleeding gums ☐ Y ☐ N

Blisters on lips or mouth ☐ Y ☐ N

Burning sensation on tongue ☐ Y ☐ N

Chew on one side of mouth ☐ Y ☐ N

Cigarette, pipe, or cigar smoking ☐ Y ☐ N

Clicking or popping jaw ☐ Y ☐ N

Dry mouth ☐ Y ☐ N

Fingernail biting ☐ Y ☐ N

Food collection between the teeth ☐ Y ☐ N

Foreign objects ☐ Y ☐ N

Grinding teeth ☐ Y ☐ N

Gums swollen or tender ☐ Y ☐ N

Jaw pain or tiredness ☐ Y ☐ N

Lip or cheek biting ☐ Y ☐ N

Loose teeth ☐ Y ☐ N

Mouth breathing ☐ Y ☐ N

Mouth pain, brushing ☐ Y ☐ N

Orthodontic treatment ☐ Y ☐ N

Pain around ear ☐ Y ☐ N

Periodontal treatment ☐ Y ☐ N

Sensitivity to cold ☐ Y ☐ N

Sensitivity to heat ☐ Y ☐ N

Sensitivity to sweets ☐ Y ☐ N

Sensitivity when biting ☐ Y ☐ N

Sores or growths in your mouth ☐ Y ☐ N

Referral who may we thank for referring you?

Insurance Company ☐ Yellow Page Ad ☐ Sign/Billboard ☐

Patient:_____ ☐ Physician:_____ ☐ Internet ☐

Walk-in ☐ Postcard or Mail Piece ☐ Other:_____ ☐

Payment &Treatment Consent

I authorize the doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to thoroughly diagnose dental needs of _____.I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I give my consent to use local anesthetics, relaxants, analgesia ("laughing gas"), antibiotics, or pain medication if deemed necessary for the completion of any dental treatment. I understand that the use of anesthetic agents embodies a certain risk. I also understand that responsibility for payment for dental services provided by this office for myself or my dependents is mine, due and payable at the time services are rendered unless other financial arrangements are made. In the event of default, I (we) promise to pay interest at the rate of 1.5% monthly on the indebtedness, together with all collection costs and reasonable attorney fees as may be required to effect the collection of this note. ***FEES NOT PAID BY THE INSURANCE COMPANY WITHIN 60 DAYS ARE PAYABLE FROM THE PATIENT OR THE RESPONSIBLE PARTY.***

Signature of Responsible Party _____Relationship to Patient_____ Date:_____

Authorization

I hereby authorize my insurance benefits to be paid directly to the doctor's office and also authorize the doctor to release any information to process insurance claims.

Date_____ Signature (Insured)_____

Dental Services Acknowledgement

- I understand that whenever a tooth is extracted, there is a possibility of infection, bone fracture, temporary paresthesia (numbness) of the lip, gum, tongue and/or facial skin. It is possible, although rare, that the paresthesia would be permanent.
- I understand that root canal treatment is an attempt to retain a tooth that would otherwise require extraction. Although root canal treatment has a high degree of success, it cannot be guaranteed. Occasionally a tooth undergoing root canal treatment may undergo acute infection. It may require re-treatment, surgery, or (rarely) extraction.
- I understand that preparation of teeth for crowns, bridges, and fillings may, on occasion, traumatize the pulp (nerve). If the pulp (nerve) is in a weakened condition, this may necessitate a root canal treatment on that tooth in the future.
- I realize that dental insurance policies restrict payment for some services, use restricted fee schedules (called usual and customary rates) and exclude some procedures based on prior conditions or length of time on plan. Posterior teeth may be paid for at "silver" or amalgam filling rate. All restrictions are based on the premium paid for insurance and not our fees or recommended treatment.
- Women taking birth control pills should be aware that antibiotics, such as penicillin or erythromycin, could possibly counteract the effects of the pill and you could become pregnant.
- I realize that any of the work that the doctor proposes can be performed by a specialist. I will tell the doctor or his staff if I desire that a specialist perform the work.
- I **DO** / **DO NOT** (circle one) grant permission to take photographs of my mouth or head and neck to used, without revealing my identity, for the furthering of medical and dental knowledge and education.
- I understand that if I fail to give a 48 hour notice to cancel a scheduled appointment I can be charged a fee up to the amount of the scheduled appointment procedure, I also understand that any X-rays taken are property of the dentist, and that a fee may be charged for any duplication or transfer of said X-rays. I have not taken any mood or mind altering drugs prior to signing this form.

Date_____ Signature_____