Welcome! Thank you for selecting our dental team. To help us meet your dental needs, please fill out these forms for us. Yes, we hate forms too, but this information is important. If you desire assistance in completing this form, our team will be happy to assist

Patient Information (Thank you for printing legibly)

Name ______________________________________ Date ______________________
I prefer to be called (Nickname) ________________________ ☐Male ☐Female
✓ Appropriate box ☐Minor ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced
Address ___________________________ City ______________ State _____ Zip_________
Birth date __________________ Social Security Number __________________________
Employer _________________________ Your Occupation _____________________
Person to contact in case of emergency ____________________ Phone ______________

How can we contact you?

Home Phone ________________ Work Phone ________________ Cell_______________
E-mail Address ____
As a courtesy we have the ability to confirm your appointments (✓check any you prefer)
☐ E-mail Message ☐Text-Message to Cell ☐Phone Call

Responsible Party (if someone other than the patient)

Unless arrangements are made in advance, the parent who brings the child to the office is responsible for payment of services
Name________________________________ Relationship to Patient ________________
Address ___________________________ City ______________ State _____ Zip _________
Home Phone ________________ Work Phone ________________ Cell _______________
Employer ________________________ Social Security Number ____________________

Referral Information

Can we thank someone for referring you?

Family Member ___________________
Coworker ______________________
Friend _________________________
Doctor _________________________

Or did you find us on your own?

☐Our website
(How did you find it?) ______________
☐Verde Valley Directory Ad
☐Other ________________________

Insurance information (Please bring your insurance card at first appointment)

Patients who carry dental insurance and fill out this section agree that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services.

Name of Insured _____________________________ Relationship to patient ___________
Birth date _______________ Social Security # _______________ # years employed ______
Name of Employer ____
Insurance Company ______________________ Group# ________ Union/Local# _______

Medical Concerns please check ✓ those that apply

Name ________________________________ Birthday ________________ Date __________

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have or medication you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following

Your current physical condition ☐Good ☐Fair ☐Poor
Have you been admitted to the hospital or needed emergency medical care in the last two years?
☐No ☐Yes for__________ ____
Are you now under the care of a physician? ☐No ☐Yes for ______________________________
____

What **MEDICATIONS** are you taking, including over the counter, i.e. Aspirin, vitamins

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Are you **ALLERGIC** to anything? ☐No ❍Penicillin ❍Latex ❍Aspirin ❍Sulfa Drugs ❍Other _______

Heart/Circulation problems ❍Heart Attack ❍Angina ❍Pace maker ❍Heart Valve
☐Yes ☐No ❍Rheumatic Fever ❍High Blood Pressure ❍Stroke
❍Heart Murmur ❍Chest Pain/Discomfort

Periodontal Disease and Dental Infections may increase the risk of Stroke and Coronary Disease

Bleeding Problems/Liver Disease
☐Yes ☐No Do you Bleed easily? **Aspirin can cause this.**
☐Yes ☐No Are you on Coumadin or other blood thinners?
☐Yes ☐No Do you have or have you had Hepatitis? ❍A ❍B ❍C ❍___ ❍Jaundice

Diabetes
☐Yes ☐No Do you have Diabetes? ❍Type 1 ❍Type2
Recent studies have shown a link between Diabetes and Periodontal Disease. It is important that they both be under control. The warning signs of diabetes are frequent trips to the bathroom, thirsty all of the time, and always feel hungry.

Breathing/Lung Problems
☐Yes ☐No Breathing Problems ❍Sinus Problems ❍Seasonal Allergies ❍Emphysema
❍Asthma ❍Bronchitis ❍Snoring ❍Tuberculosis
☐Yes ☐No Do you wear a CPAP for sleeping?

Cancer
☐Yes ☐No Do you have cancer?
☐Yes ☐No Have you ever had cancer? When?____________ What Kind? __________________
How are you or were you being treated? ❍Surgery ❍Chemotherapy ❍Radiation

Joint Replacement
☐Yes ☐No If so, When? ________________________

Females
Are you pregnant? ☐Yes ☐No Nursing?☐Yes ☐No Taking birth control pills? ☐Yes ☐No

General Questions
☐Yes ☐No Do you have a Mental Health Disorder? What is it? ____________________________
☐Yes ☐No Immune System Problems? ❍Lupus ❍Organ Transplant ❍HIV ❍AIDS
☐Yes ☐No Do you have Glaucoma?
☐Yes ☐No Do you have or have you had any sexually transmitted diseases? VD Herpes
☐Yes ☐No Any Epilepsy/Convulsions/Fainting/Seizure history?
☐Yes ☐No Have you been treated with Bisphosponates? (Fosamax,Aredia, Zometa, Actonel,Boniva)
☐Yes ☐No Do you have health problems that need further clarification? ____________________

Patient Dental History

Please check any of the following that apply to you:

❍ Sensitivity (hot, cold, sweet)
If so, which teeth?
❍ Sensitivity to biting
❍ Headaches, earaches, neck pain
❍ Problems with your Jaw
❍ Teeth or fillings breaking
❍ Grinding or clenching teeth
❍ Bleeding, swollen, or irritated gums
❍ Loose, tipped, or shifting teeth
❍ Bad breath
❍ Dry Mouth

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

❍ Dentures
❍ Partial Dentures
❍ Periodontal (gum) treatments

Please share the following approximate dates:

Your last cleaning ____________________

Your last oral cancer screening _________

Your last complete x-rays _____________

Who was your previous dentist?

Name: ______________________________

City: ___________________ State: ______

Phone: ______________________________

Why did you leave your previous dentist?

What is the most important things to you about your smile and dental health?

What's more fun than today's visit?

Do you smoke or use chewing tobacco?

❍ Yes ❍ No

If yes, how much? And, for how long?

If you could change your smile, would you:

(please check all that apply)

❍ Make your teeth whiter
❍ Make your teeth straighter
❍ Close spaces between teeth
❍ Replace black metal fillings
with tooth-colored restorations
❍ Repair chipped teeth
❍ Replace missing teeth
❍ Replace old crowns or fillings that don't match
❍ Have a smile makeover

Has fear kept you from seeking dental care?

❍Yes ❍No

Would you like to know more about anxiety-free dentistry?

❍Yes ❍No

On a scale of 1 to 5, with 5 being the highest:
(please circle the number that best applies)

How important is your dental health to you?

1 2 3 4 5

How would you rate your current dental health?
1 2 3 4 5

Where do you want your dental health to be?

1 2 3 4 5

If you could whiten your teeth, at a cost that anyone could afford, would you like to?

What is the most important thing to you about your visit today?

If you have dental insurance please choose one of the following options

We are committed to providing you with the best possible care. If you have dental insurance, we would be pleased to assist you in receiving your maximum allowable benefits. To achieve these goals we need your assistance and understanding of your financial arrangement with our office.

Our staff will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize however:

1. Your insurance is a contract between you, your employer, and your insurance company.
2. The insurance coverage you will receive depends on the quality of the plan purchased by the employer. Plans vary greatly and insurance companies do not give us the exact reimbursement amounts. Please contact your insurance company if you need an exact reimbursement amount.
3. While filing insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

☐ I authorize my insurance company to make payments directly to the dental office for benefits otherwise payable to me. I will be paying my estimated co-pay at the time of treatment and my credit card number will be kept on file. I hereby authorize Roy Daniels, DDS, PLC to keep my signature on file and to charge my credit card account for any and all treatment fees remaining after my insurance carrier has processed my claim, or any balance still remaining after 45 days. A receipt will be mailed to me.

Cardholder's Name ___________________________________
Cardholder's Signature________________________________
Cardholder's Address _______________________________ City ________________ State ______
Zip_________
☐MasterCard ☐Visa ☐AMEX ☐Discover ☐Care Credit
Credit Card # ____ Exp date __________ CCV_____

☐ I will be paying the FULL AMOUNT of my appointment at the time of service by one of the following: CASH, CHECK, CREDIT CARD or 3rd Party Financing. Roy Daniels, DDS, PLC will file my insurance on my behalf and will request the benefits be reimbursed to me.

Authorization

I authorize release of my records to third party payers, other healthcare professionals or operations, or other entities as deemed necessary by this office. I authorize use of this signature for all insurance submissions.

I understand that I am responsible for all charges whether or not they are covered by insurance, as well as any additional collection costs if this office determines they are necessary. I understand that a service charge of 1.75% a month (21% per annum) on the unpaid balance will be charged on accounts exceeding 45 days unless previously written financial arrangements have been made. I understand that in certain circumstances, my credit report may be requested. I have reviewed the information on this form, and it is accurate to the best of my knowledge.

I agree to give at least 48 hour notice when needing to cancel or change an appointment. Not providing the notice will result in a charge of $50.00 for the appointment time.

I have received a copy of this office's Notice of Privacy Practices.

Signature ______________________________________Date_______________________

❍Ins Photocopy ❍ID ❍HIPPA ❍