



Roy G. Daniels DDS

Dentistry
Cosmetic • General • Implant

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

Yes No

Heart Attack Angina Pace maker Heart Valve

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 Type 2

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 Bisphosphonates? (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
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