Specializing in Healthy Smiles

LARSON DENTAL

8086 E. Florentine Rd.
Prescott Valley, AZ 86314
(928) 772-8128
www.kellylarsondds.com

Welcome to our Practice

Chart #_____
(FOR OFFICE USE ONLY)

Patient Name: _____
Last First MI Preferred Name

Title_____ ___M ___F Family Status: ___Married ___Single ___Child ___Other
(Mr/Mrs/Ms/etc)

Birth Date:_____ SS#: _____ Previous Visit: _____

Email: _____ Best time to call: _____

Home Phone:_____ Cell Phone: _____

Work Phone:_____ Other:_____

Address:_____

The following is for: ___the patient ___the person responsible for payment

Employer Name:_____ Phone:_____

Address:_____

Whom may we thank for referring you to our practice? _____

In case of an emergency:

Name:_____ Relationship: _____

Primary Phone:_____ Work Phone: _____

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Medical History

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- ☐ *None listed
- ☐ Acid Reflux
- ☐ Allergy - Aspirin
- ☐ Allergy - Codeine
- ☐ Allergy - Latex
- ☐ Allergy - Metal
- ☐ Allergy - Penicillin
- ☐ Allergy - Seasonal
- ☐ Allergy - Sulfa
- ☐ Allergy - Anesthetics
- ☐ Allergy - Tetracycline
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma - Respiratory
- ☐ Blood Thinner
- ☐ Cancer
- ☐ Chest Pains
- ☐ Convulsions
- ☐ COPD
- ☐ Diabetes
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Fibromyalgia
- ☐ Frequently Tired
- ☐ Glaucoma
- ☐ Growths/Tumors
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Trouble
- ☐ Hepatitis/Jaundice
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Liver disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolaps
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Premedicate
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sleep Apnea
- ☐ Stomach Prob/Ulcers
- ☐ Stroke
- ☐ Swollen Ankles
- ☐ Thyroid Problem
- ☐ Tobacco/E-Vape User
- ☐ Tuberculosis
- ☐ Valve Replacement
- ☐ Venereal Disease

Substance Abuse History: Y_____ N_____

☐ Currently Pregnant?

Other not listed above:_____

_____

Please describe below if any of the above need further clarification: _____

_____

_____

_____

_____

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Previous Dentist Name and Phone Number and date of last exam and X-rays:

_____

What is your immediate concern?

_____

Check all that apply:

- ☐ Had complications from past dental treatment or had trouble getting numb
- ☐ Had any reactions to local anesthetic
- ☐ You experience dry mouth
- ☐ Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
- ☐ Food gets trapped between any teeth
- ☐ Have you experienced popping and/or clicking of your jaw joint
- ☐ You clench or grind your teeth
- ☐ You wear or have worn a bite appliance
- ☐ Gums bleed when brushing or flossing or you have experienced gum recession
- ☐ Treated for gum disease or were told you have lost bone around your teeth
- ☐ Noticed an unpleasant taste or odor in your mouth
- ☐ Had any teeth become loose on their own (without injury)
- ☐ Do you snore or wake up frequently during the night

If any of the checked boxes need further explanation, please describe:

_____

_____

_____

_____

_____

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Check all that apply:

☐ Hypertension ☐ Snoring ☐ Diabetes
☐ Depression ☐ Grind Teeth ☐ Acid Reflux
☐ Stroke/Heart Disease ☐ Unrefreshed Sleep
☐ Family history of Snoring or Sleep Apnea

Have you ever been told you stop breathing while asleep?	☐ Yes	☐ No
Have you ever fallen asleep or nodded off while driving?	☐ Yes	☐ No
Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?	☐ Yes	☐ No
Do you feel excessively sleepy during the day?	☐ Yes	☐ No
Do you snore or have you ever been told that you snore?	☐ Yes	☐ No
Have you had weight gain and found it difficult to lose?	☐ Yes	☐ No
Have you taken medication for, or been diagnosed with high blood pressure?	☐ Yes	☐ No
Do you kick or jerk your legs while sleeping?	☐ Yes	☐ No
Do you feel burning, tingling or crawling sensations in your legs when you wake up?	☐ Yes	☐ No
Do you wake up with headaches during the night or In the morning?	☐ Yes	☐ No
Do you have trouble falling asleep?	☐ Yes	☐ No
Do you have trouble staying asleep once you fall asleep?	☐ Yes	☐ No
Have you ever been diagnosed with a sleep disorder?	☐ Yes	☐ No
Are you currently using a CPAP machine?	☐ Yes	☐ No
Do you use your CPAP less than 5 times a week?	☐ Yes	☐ No
Would you prefer an oral appliance?	☐ Yes	☐ No

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Do you take antibiotic premedication for your dental visits? If yes, please explain:

_____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of your primary care physician and phone number:

_____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

List all medications (prescription and non-prescription) Including regular doses of aspirin:

_____

_____

Are you able to lay flat in a dental chair? Y_____ N_____

I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.

X _____

Signature of Patient (Or Parent/Guardian if Minor) *Date*

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Office Financial Policy

1. Payment is due on the day of service. Financing is available through Care Credit, OAC. Our office will be happy to help you with your Care Credit application. Dr. Larson does not offer any in-house financing.

2. The financial agreement for treatment will be discussed and fees established before an appointment date is made.

3. Patients who carry dental insurance must understand that they are responsible for all dental services provided regardless of insurance benefits. Our office will assist in making collections from the insurance company by filing the necessary forms, however, we cannot render services based on the assumption that charges will be paid by the insurance company.

4. Valid insurance information is required at the time of service. If you are unable to provide a copy of your current insurance card, you will be listed as self-pay until you are able to provide the office with a copy. We request that you provide current insurance information within 5 days of the date of service.

5. All insurance companies have timely filing limits for claims. Failure to provide correct insurance information in a timely manner to our office will result in patient/guarantor responsibility for the claim(s). Due to filing limits, we will no longer accept new insurance information for a previous service after 45 days. It will be the responsibility of the patient/guarantor to pay the claim and seek reimbursement from the insurance carrier.

6. If we have reserved an appointment for you that is one hour or less, and you are unable to keep this appointment, please call at least 24 hours in advance or a $50.00 fee may be charged to your account. If we have reserved an appointment for you that is more than one hour and you are unable to keep this appointment, please call at least 48 hours in advance or a $100.00 fee may be charged to your account.

I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration Form.

X _____

Signature of Patient (Or Parent/Guardian if Minor) *Date*

HIPAA Acknowledgment

I understand that I may ask the office for a copy of the HIPAA policy or I may view ii on the website at www.kellylarsondds.com. I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any lime, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.

X _____

Signature of Patient (Or Parent/Guardian if Minor) *Date*

*Response Date*_____

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What bothers you most about your smile?

_____

Are there any spaces you do not like? Yes/No

Is crowding a problem? Yes/No

Explain: _____

Do you have any chips, stains, etc. that bother you? Yes/No

Explain: _____

Do you like the shape of your teeth? Yes/No

Explain: _____

Do you like the way your bottom teeth and top teeth fit together? Yes/No

Explain: _____

Are your teeth as bright as you would like? Yes/No

Explain: _____

Has anyone ever shown you what you'd look like if you changed your smile? Yes/No