

Specializing in Healthy Smiles



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

www.prescottvalleyfamilydentistry.com

Welcome to our Practice

Patient Name: _____
Last First MI Preferred Name

Title _____ M F Family Status: ___Married ___Single ___Child ___Other
(Mr/Mrs/Ms/etc)

Birth Date: _____ SS#: _____

Email: _____

Home Phone: _____ Cell Phone: _____

Address: _____ Zip _____

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

Who may we discuss your care with? _____ Phone _____

In case of an emergency:

Name: _____ Relationship: _____

Primary Phone: _____ Work Phone: _____

At your first visit, please provide a copy of your insurance card. We are exclusively contracted with Delta Dental as Premier Providers. We do accept any dental insurance as long as they pay for out of network services.

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



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.

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> *None listed | <input type="checkbox"/> Asthma - Respiratory | <input type="checkbox"/> Biophosphates | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Blood Thinner | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Allergy - Aspirin | <input type="checkbox"/> Cancer | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Premedicate |
| <input type="checkbox"/> Allergy - Codeine | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Allergy - Latex | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergy - Metal | <input type="checkbox"/> COPD | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Allergy - Penicillin | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Allergy - Seasonal | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Stomach Prob/Ulcers |
| <input type="checkbox"/> Allergy - Sulfa | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergy - Anesthetics | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> HIV | <input type="checkbox"/> Swollen Ankles |
| <input type="checkbox"/> Allergy - Tetracycline | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Tobacco/E-Vape User |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Frequently Tired | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Valve Replacement |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolaps | <input type="checkbox"/> 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 _____
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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 it on the website at www.prescottvalleyfamilydentistry.com. I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, 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 _____
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_____ *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
