SERENITY VALLEY
Family Dentistry

We are happy to have you join our great family of patients and friends. Please complete this form so that we can provide the best care possible for you.

Thank you!

ABOUT YOU

Name:_____ ☐ Female ☐ Male

Address: _____

City: _____ State:_____ Zip: _____

_____

Home phone: _____ Cell phone:_____

Birth date: _____/_____/_____ Marital status: ☐ Single ☐ Married ☐ Widowed

E-mail address: _____

Who can we thank for referring you? _____

EMERGENCY INFORMATION

Person to contact: _____

Relationship:_____ Phone: _____

I give permission for Serenity Valley Family Dentistry to share my medical and account information with: _____

DENTAL HISTORY

Have you ever had:

☐ orthodontic treatment?
☐ oral surgery?
☐ root canal treatment?
☐ clicking or popping of the jaw joint (TMJ)?
☐ muscle tenderness in jaw/teeth?
☐ sensitivity to heat, cold or pressure?

Do you smoke or chew tobacco? ☐ Yes ☐ No

Are the four food groups part of your daily diet? ☐ Yes ☐ No

If Not, what type of foods do you eat? _____

How often do you brush your teeth? _____How often do you floss your teeth? _____

Have your past experiences in dentistry been good or bad? _____

Date of your last hygiene visit? _____/_____/_____

What is the main reason for your visit today?

☐ Tooth pain
☐ Orthodontics (Invisalign)
☐ I need a check-up
☐ Whitening
☐ Cleaning
☐ Cosmetic dentistry
☐ Other _____

On a scale of 1 to 5 (1 low/poor, 5 high/good) please:

What is your level of sensitivity to dental procedures? _____ 1 2 3 4 5

How do you feel about your smile and the look of your teeth? _____ 1 2 3 4 5

I would like to learn more about:

- ☐ Cosmetic dentistry
- ☐ Orthodontics (Invisalign)
- ☐ Whitening
- ☐ Veneers
- ☐ Implants
- ☐ Bridges
- ☐ Same-day Crowns
- ☐ Dentures
- ☐ Other _____

Medical History

Name of personal physician: _____

Address: _____ Phone number: _____

Approximate date of last visit:_____ Current health condition: ☐ Excellent ☐ Good ☐ Fair Poor

Have you had any serious health problems in the last five years ☐ Yes ☐ No If Yes, please explain: _____

_____

(For women) Are your currently pregnant? ☐ Yes ☐ No If Yes, how many months? _____

Please list prescription medications: _____

_____

Please list vitamin/herbal supplements? _____

Please check if you're allergic to any of the following:

- ☐ Local anesthetics
- ☐ Penicillin/other antibiotics
- ☐ Barbiturates, sedatives, sleeping pills
- ☐ Sulfa drugs
- ☐ Aspirin
- ☐ Shellfish, iodine or red wine
- ☐ Codeine/other narcotics
- ☐ Latex sensitivity
- ☐ Other_____

Do you have, or have you had, and of the following?

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pace Maker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

The information I have given is true and accurate to the best of my knowledge.

Patient Name _____ (internal use)

APPOINTMENT POLICY

Please arrive on-time to your scheduled appointment. Late arrivals cause schedule delays for those patients who arrive on time. Late arrivals will be worked into the schedule if **time allows or re-appointed** to another day.

The scheduled appointment is reserved specifically for you. Any change in this appointment affects many other patients. If a cancellation is unavoidable, please call the office **at least 48 hours** in advance so we may offer that time to other patients.

Most insurance companies only pay a portion of the fees incurred. We require your portion to be paid at the time the procedure(s) take place (unless financial arrangements have been made). We try to get an estimate from your insurance company on your portion, but they ultimately decide if and at what percentage treatment is covered at, at the time the claim is filed. You are responsible for all charges not paid by insurance. As a courtesy to you, we will bill your insurance carrier for you. By signing below, you authorize the doctor to release all information necessary to secure the payment of benefits to our office.

For appointments that are 2 hours or longer, a $50 deposit is required to hold this spot. This deposit is non-refundable for missed, cancelled, or rescheduled appointments (otherwise, this amount will be subtracted from the payment due day of service). I understand that I am responsible for all fees pertaining to my unpaid balance and/or missed appointments. You may be charged a billing charge per month of $15 if my balance goes beyond 60 days. Any balance after 90 days will be sent to collections.

I give permission for my dentist to take any necessary radiography, study models, and photographs to make a complete diagnosis of my dental needs. I also give permission for my dentist and dental team to use my photographs for in-office patient education.

Every effort will be made to confirm my appointment by Serenity staff and if it is not confirmed within 24 hours of the appointment, I understand that it can be removed due to no confirmation.

Signature _____ Date _____/_____/_____

Parent's Signature (If under 18) _____ Date _____/_____/_____
(I have read, agree to, and understand the statements listed above)

APPOINTMENT CANCELLATION POLICY
When we schedule an appointment, we reserve that time and prepare in anticipation of serving you. If you should need to reschedule, we kindly request that you contact us by phone with advanced notice of two working business days. We understand that conflicts arise; however, failing your appointment or cancelling multiple times without notice will result in a $50 charge and then discontinuation of services
Initials:_____