

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 p	phone:
Birth date:/ Marital status: ☐ Single ☐ M	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 sh	are 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 ☐ I If Not, what type of foods do you eat?	No
How often do you brush your teeth? Have your past experiences in dentistry been good or bad? Date of your last hygiene visit?//	How often do you floss your teeth?
What is the main reason for your visit today? □ looth pain □ Whitening □ Orthodontics (Invisalign) □ Cleaning □ I need a check-up □ Cosmetic dentis	□Other

Serenity Valley Family Dentistry Eaglesoft Medical Kistory (UPDATED)

Birth Date:

Date Created:

Patient Name:

					.,				
Although dental personne	d primarily treat the a	rea in and around	your mouti	h, your mo	uth is a pa	rt of your entire body. Health	problems that you	ı may have, or medication t	nat you may be tak
Are you under a physician's care now?			OYes (ONo	If yes				
Have you ever been hospitalized or had a major operation?			O Yes	ONo	If yes				
Have you ever had a ser	rious head or neck in	ijury?	○Yes(ONo	If yes			<u></u>	
Are you taking any medications or supplements? Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?		nts?	○Yes		If yes				
		○Yes	ONo	If yes					
Do you use tobacco?			○Yes (ON₀					
Do you use controlled substances?			○Yes(O No	If yes				-
omen: Are you									
Pregnant			Nursin	g?		Taking oral contraceptives?			
re you allergic to any of th	ne followina?								
Aspirm	·••	Penicillin				Codeine	Codeine		
Metal		Latex				☐ Sulfa Drugs		Local Anesthetics	
Other?					If yes			**************************************	
o you have, or have you i	had any of the follow	ino?		*****					
AIDS/HIV Positive	Oyes Ono	Radiation/Cher	motherapy	() Yes	ON₀	Diabetes	OYes ONo	Hepatitis	○Yes ○No
High Blood Pressure	○Yes ○No	Treatments		_	_	Epilepsy or Seizures	○Yes ○No	High Cholesterol	○Yes ○N
Artificial Heart Valve	○Yes ○No	Arthritis		() Yes	_	Artificial Joint	○Yes ○No	Asthma	○Yes ○N
Sinus Trouble	○Yes ○No	Bleeding disor		O Yes	_	Stomach/Intestinal Disease	○Yes ○No	Breathing Problems	○Yes ○Ne
Frequent Headaches	○Yes ○No	Kidney Problem	8	() Yes		Stroke	○Yes ○No	Low Blood Pressure	○Yes ○No
Cancer	○Yes ○No	Liver Disease		O Yes		Lung Disease	○Yes ○No	Mitral Valve Prolapse	○Yes ○No
Chest Pains	○Yes ○No	Glaucoma		() Yes	-	Osteoporosis	OYes ONo	Tuberculosis	○Yes ○No
Pain in Jaw Joints	○Yes ○No	Heart Attack/Fa		O Yes		Heart Pacemaker	○Yes ○No	Heart Disease	Oyes On
Anxiety/Depression	○Yes ○No	Congenital Hea	rt Disorder	Yes OYes	_	Sleep disorder	○Yes ○No		
Have you ever had any se	erious illness not list	ed above?	OYes (ON0	If yes				
omments/Emergency cont	bet						**************************************		
America) chargaily total	**************************************						and an 		Anadagear a parriage data as
	······					*****			

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

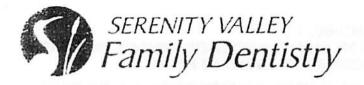
Signature of Patient, Parent or Guardian:

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

copy of the currently effective Notice of Privacy Practices for this document shall be as effective as the original. MY SIGNATURE WILL SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO THE FUTURE.				
Please sign Patient / Guardian of Patient				
Relationship of Legal Representative / Guardian				
MMONED FROM RECEPTION AREA:				
r Surname '3 Other				
/ELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO ints, grandparents and any care takers who can have access to this patient's records): Relationship:				
Relationship:				
FIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA: L'Email Confirmation Any of the Above BE CONVEYED VIA: Email Confirmation Work Phone Confirmation Any of the Above				
TERVICES, EVENTS, FUND RAISING EFFORTS of NEW HEALTH INFO on				
☐ Any of the Above ☐ None of the Above (opt out)				
ge and authorize, that this office may recommend products or services to promote your improved health. Affiliated companies. We, under current HEPAA Consibus Rule, provide you this information with your knowl-				
d signature on this Acknowledgement but did not because:				



Thank you for choosing Serenity Valley Family Dentistry. We believe that it is our responsibility to use our best professional care, skill, and judgement in helping you achieve your dental health goals.

We reserve your scheduled appointment time just for you. As a courtesy to our team and other patients in the schedule, please arrive on time. Late arrivals will be worked into the schedule if time allows or reappointed to another day.

We will verify your insurance however, verification is not a guarantee of payment. You are responsible for all charges not paid by insurance at your scheduled appointment. Any balance after 90 days will be sent to collections.

If you need to reschedule your appointment, we kindly request that you contact us by phone with advanced notice of 2 business days. We understand that situations can arise although, failing your appointment or cancelling multiple times without notice will result in discontinuation of services at our office.

Our office will make every effort to confirm your appointment. If it goes unconfirmed 24 hours prior to the appointment, we reserve the right to take you out of the schedule due to no confirmation.

Signature	Date:			
Parents signature if under 18				