

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:

- | | | |
|--|-----------------------------------|--|
| <input type="checkbox"/> Cosmetic dentistry | <input type="checkbox"/> Veneers | <input type="checkbox"/> Same-day Crowns |
| <input type="checkbox"/> Orthodontics (Invisalign) | <input type="checkbox"/> Implants | <input type="checkbox"/> Dentures |
| <input type="checkbox"/> Whitening | <input type="checkbox"/> Bridges | <input type="checkbox"/> 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 you 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:

- | | | |
|---|--|--|
| <input type="checkbox"/> Local anesthetics | <input type="checkbox"/> Sulfa drugs | <input type="checkbox"/> Codeine/other narcotics |
| <input type="checkbox"/> Penicillin/other antibiotics | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Latex sensitivity |
| <input type="checkbox"/> Barbiturates, sedatives,
sleeping pills | <input type="checkbox"/> Shellfish, iodine or red wine | <input type="checkbox"/> Other _____ |

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

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