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

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 reappoint 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 _____/_____/_____

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