CANYON CREST DENTAL

Patient Information

Name: *Last* *First* *Middle Initial* | Preferred Name: | Title (Mr/Ms/Mrs etc.)

Gender: ☐ Male ☐ Female | Family Status: ☐ Married ☐ Single ☐ Child ☐ Other | Date of Birth: | Previous Visit:

Email Address: | Home Phone: *Include area code* ( ) | Work Phone: *Include area code* ( ) Ext. | Cell Phone: *Include area code* ( ) | Best time to call:

Address: *Mailing address* | City: | State: | Zip:

Preferred appointment times:

☐Mon ☐Tue ☐Wed ☐Thurs ☐Fri ☐Sat ☐ Morning ☐ Afternoon ☐ Evening ☐ Any time

Whom may we thank for referring you to our practice? | Name of person, office, or other source referring you to our practice:

☐Dental Office ☐Yellow Pages ☐Internet ☐Newspaper ☐School ☐Work ☐Other

Spouse or Responsible Party Information

The following is for:

☐ The patient's spouse ☐ The person responsible for payment ☐ Neither applicable

Name: *Last* *First* *Middle Initial* | Preferred Name: | Date of Birth:

Email Address: | Home Phone: *Include area code* ( ) | Work Phone: *Include area code* ( ) Ext. | Cell Phone: *Include area code* ( ) | Best time to call:

Address: *Mailing address* | City: | State: | Zip:

Employment

The following is for:

☐ The patient's spouse ☐ The person responsible for payment

Employer Name: | Phone: ( )

Address: *Mailing address* | City: | State: | Zip:

Primary Insurance Information

Primary Dental Insurance:

Name of the Insured: *Last* *First* *Middle Initial* | Date of Birth: | ID #: | Group #:

Insured's Address: *Mailing address* | City: | State: | Zip:

Insured's Employers Name:

Employer's Address: *Mailing address* | City: | State: | Zip:

Patient's relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other | Insurance Plan Name:

Insurance Address: *Mailing address* | City: | State: | Zip:

Primary Medical Insurance:

Name of the Insured: *Last* *First* *Middle Initial* | Patient's relationship to insured ☐Self ☐ Spouse ☐ Child ☐ Other | Insurance Plan Name:

Secondary Insurance Information

Secondary Dental Insurance:

Name of the Insured: Date of Birth: ID #: Group #:

Last *First* *Middle Initial*

Insured's Address: City: State: Zip:

Mailing address

Insured's Employers Name:

Employer's Address: City: State: Zip:

Mailing address

Patient's relationship to insured Insurance Plan Name:

☐Self ☐ Spouse ☐ Child ☐ Other

Insurance Address: City: State: Zip:

Mailing address

Secondary Medical Insurance:

Name of the Insured: Patient's relationship to insured Insurance Plan Name:

Last *First* *Middle Initial* ☐ Self ☐ Spouse ☐ Child ☐ Other

Handle me with care

Put a checkmark in the box next to the statement that concerns or descibes you:

- ☐ I gag easily
- ☐ I feel out of control while I'm lying down in the dental chair
- ☐ I have not been to a dentist for a long time and I am worried about what you will tell me about my teeth and my dental hygiene
- ☐ I am embarrassed about the way my teeth look
- ☐ I have had a bad dental experience and have a lot of fear which has kept me from getting the dental care I need
- ☐ I am very apprehensive about the possibility of experiencing any pain. Therefore, pain relief is a top priority for me
- ☐ Please tell me what I need to know about my mouth so that I can make informed decisions
- ☐ I want to be able to ask as many questions as necessary so that I understand why and what treatment is being recommended for me
- ☐ I have difficulty listening and remembering when I am in the dental chair
- ☐ I would like to see pictures and videos that will help me understand my dental problems and their solutions
- ☐ I will need help with financing options so that I can spread my payments out over time
- ☐ Other

Notice of Privacy Practices and Dental and Medical Information Release Form (HIPAA)

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

* Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
* Obtain payment from third-party payers.
* Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I can receive your complete Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

Signature of patient or patient's representative Date:

Print Name Relationship to Patient (if not signed by the patient)

The following is a list of people this clinic may discuss my dental care needs with, including billing and appointment scheduling issues. _____

Thank you for choosing our office to meet your dental needs.

We make every effort to give the perfect patient experience. For your comfort we offer nitrous oxide (laughing gas) and sedation dentistry. Please let us know if you would be interested in either of those options. We also have pillows, blankets, TV's, music and wireless earphones available. Shortly after completing your professional cleaning or treatment with the Dr. you will be provided with a warm towelette.

To assure that you receive the best dental care in an efficient and timely manner we reserve appointments exclusively for you. If you need to change or cancel an appointment please notify us within 48 hours to avoid a $75.00 cancellation fee. If an appointment is cancelled or failed multiple times a deposit may be required to reserve your future appointments.

We strive to provide excellent customer service and satisfaction. If you ever feel that you were given less than excellent service, we ask that you inform us immediately. Your feedback is important to us.

We look forward to serving you and appreciate your patronage.

Signature Date: Print Name

Dental insurance is a contract between the patient or employer with the insurance company. The dental office has no control of payments or reimbursement by the insurance company. We will make every effort possible to assist you with your particular coverage. Although it is not required, we will prepare and submit your insurance claim at no cost as a courtesy to our patient. We will also provide an "ESTIMATE" of cost that is due at the time of treatment. Should our "ESTIMATE" be too high, a refund will be issued. Likewise, if the "ESTIMATE" was low, the remainder will be due at that time. Should no insurance payment be made within ninety days of a submitted claim, the fee will become the sole responsibility of the patient.

Patient's name (please print) Signature of patient or legal guardian

Health History Form

CANYON CREST DENTAL

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: *Last* *First* *Middle*

Home Phone: *Include area code* ( )

Business/Cell Phone: *Include area code* ( )

Address: *Mailing address*

City: State: Zip:

Occupation:

Height: Weight: Date of Birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship:

Home Phone: *Include area code* ( )

Cell Phone: *Include area code* ( )

If you are completing this form for another person, what is your relationship to that person?

Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the the question)*

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Are you currently under the care of a physician due to a specific condition	☐	☐	☐

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? *Circle one:* DAILY / WEEKLY / OCCASIONALLY	☐	☐	☐
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam: Date of last dental x-rays:

What was done at that time:

How frequently do you brush your teeth:

How frequently do you floss your teeth:

When was your last visit to the dentist?

Are any of your teeth loose, or are you concerned about any teeth loosening?: ☐ ☐ ☐

Prior Dentist's name, address, & phone number?

What is the reason for your dental visit today?

How do you feel about your smile?

If you could change anything about your mouth, teeth, or smile, what would it be:

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question)

Do you wear contact lenses? Yes No DK

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Yes No DK

Date: _____ If yes, have you had any complications? _____

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? Yes No DK

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Yes No DK

Date Treatment began: _____

Do you use controlled substances (drugs)? Yes No DK

Do you use tobacco (smoking, snuff, chew, bidis)? Yes No DK

If so, how interested are you in stopping?
Circle one: VERY / SOMEWHAT / NOT INTERESTED Yes No DK

Do you drink alcoholic beverages? Yes No DK

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink i n a week? _____

WOMEN ONLY Are you:

Pregnant? Yes No DK

Number of weeks: _____

Taking birth control pills or hormonal replacement? Yes No DK

Nursing? Yes No DK

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: _____			
Recurrent Infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes No DK

Name of physician or dentist making recommendation:

Phone: *Include area code*
( )

Do you have any disease, condition, or problem not listed above that you think I should know about? Yes No DK
Please explain:

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments: