Desert Dental Spa

We would like to get to know you better

one About You

Today's Date: ____ / ____ / ____ File# ____

Patient Name: ____
FIRST LAST MI

What you prefer to be called: ____ ❑ Male ❑ Female

Birthday ____ / ____ / ____ Age: ____ SS# ____

Mailing Address ____

____
CITY STATE ZIP

Home Phone #: ( ) ____

Work Phone #: ( ) ____ Ext. ____

Cell Phone #: ( ) ____

E-mail address: ____

Referred by: ____

Employer: ____ How long? ____

Employer's address: ____

____
CITY STATE ZIP

Occupation: ____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's name: ____

Do you have children? ❑ Yes ❑ No How Many? ____

two Account Info

Primary Dental Insurance

Co. Name: ____

Address: ____

____
CITY STATE ZIP

Phone #: ( ) ____

Insured's ID#: ____

Group # (Plan, Local or Policy #): ____

Insured's Name: ____

Relation: ____ Date of Birth ____/____/____

Insured's Employer: ____

Secondary Dental Insurance

Co. Name: ____

Address: ____

____
CITY STATE ZIP

Phone #: ( ) ____

Insured's ID#: ____

Group # (Plan, Local or Policy #): ____

Insured's Name: ____

Relation: ____ Date of Birth ____/____/____

Insured's Employer: ____

three Account Info

Person ultimately responsible for account

Name: ____

Relation: ____

Billing Address: ____

____
CITY STATE ZIP

SS#: ____

Drivers License #: ____

Work Phone #: ( ) ____

Payment method: ❑ Cash ❑ Check

____ ___/___

❑ Credit Card - Enter card # above (if accepted)

____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
initials

four In Case of Emergency

Whom should we contact? ____

Relation: ____

Home Phone #( ) ____

Work Phone #( ) ____

Cell Phone #( ) ____

Who is your medical doctor? ____

Medical Doctor's Phone # ( ) ____

Please continue on back

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Dental Information

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation

Are you in pain? ❑ No ❑ Yes How Long? _____

Please indicate ☑ any of the following problems:

❑ Discomfort, clicking or popping in jaw.	❑ Lost/Broken Filling(s)	❑ Stained teeth
❑ Red, swollen or bleeding gums.	❑ Teeth grinding	❑ Locking Jaw
❑ Sensitive tooth, teeth or gums.	❑ Ringing in Ears	❑ Bad breath
❑ Blisters/Sores in or around the mouth.	❑ Broken/Chipped tooth	

❑ Other: _____

Do you require pre-medication? ❑ Yes ❑ No ❑ Don't know

Previous Dentist: _____ ( ) _____
Name Phone #

Last Dental exam: ____/____/____ Last Dental X-rays: ____/____/____

Times a day you brush? _____ Times a week you floss? _____

What type of brush do you use? ❑ Soft ❑ Medium ❑ Hard

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

6six

Medical History

What medications are you taking? ❑ Nerve pills ❑ Pain killers (including aspirin) ❑ Muscle relaxers ❑ Stimulants ❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Meds for Osteoporosis ❑ Other(s), please list: _____

Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) ❑ Yes ❑ No Phen-fen/Redux ❑ Yes ❑ No

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack/Stroke	**Y N** Thyroid Problems	**Y N** Cancer/Tumors	**Y N** Cosmetic Surgery
Y N Heart Surg./Pacemaker	**Y N** Kidney Problems	**Y N** Shingles	**Y N** Xray or Cobalt Treatment
Y N Heart Murmur	**Y N** Liver Problems	**Y N** Hepatitis	**Y N** Chemotherapy
Y N Rheumatic Fever	**Y N** Respiratory Problems	**Y N** HIV+/AIDS/ARC	**Y N** Asthma
Y N Mitral Valve Prolapse	**Y N** Sinus Problems	**Y N** Arthritis/Rheumatism	**Y N** Difficulty Breathing
Y N Artificial Valves	**Y N** Stomach Problems/Ulcers	**Y N** Artificial Bones/Joints	**Y N** Diabetes/Hypoglycemia
Y N Heart Disease	**Y N** Psychiatric Problems	**Y N** Emphysema	**Y N** Leukemia
Y N Congenital Heart Defect	**Y N** Venereal Disease	**Y N** Fainting/Seizures /Epilepsy	**Y N** Anemia
Y N Chest Pains	**Y N** Alcohol/Drug Abuse	**Y N** Severe/Frequent Headaches	**Y N** High/Low Blood Pressure
Y N Scarlet Fever	**Y N** Tuberculosis TB	**Y N** Frequent Neck Pain	**Y N** Bleeding Problems
Y N Nervousness	**Y N** Jaw Problems TMJ/TMD	**Y N** Back Problems	**Y N** Glaucoma

Please list any other surgeries or medical conditions you have or ever had: _____

_____

Are you allergic to any of the following? ❑ Latex ❑ Penicillin/Amoxicillin ❑ Tetracycline ❑ Aspirin

❑ Dental Anesthetics ❑ Foods: _____ ❑ Others: _____

Do you use tobacco? ❑ No ❑ Yes/How used? _____ How much? _____ How long? _____

Please rate your general health from 1-10: _____ Do you wear contact lenses? ❑ Yes ❑ No

For women: Are you taking Birth Control pills? ❑ Yes ❑ No How many children have you had? _____

Are you Pregnant? ❑ No ❑ Yes/How long? _____ Are you nursing? ❑ Yes ❑ No

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____/____/____

❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

Patient Acknowledgment and Consent Form

fective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information at we have collected and will collect in the future.

o comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of ivacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices. Existing Michigan w requires (in addition to our attempt to obtain your written acknowledgment, discussed above) us to first obtain your written nsent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim allenging our professional competence; a review entity's functions: a claim for payment of fees; a third party payer's amination of our records: a court order as part of a criminal investigation: an identification of a dead body; a licensure vestigation; or a child abuse/neglect investigation.

om time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For ample, we may make a referral to or consult with another dentist or health care professional, provide a specimen to a laboratory r testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgment

lease sign this form below under the heading "acknowledgment" to acknowledge that you have today received a copy of our notice of privacy ractices.

acknowledge that I have today received a copy of the Notice of Privacy Practices.

X_____ _____ X_____

atient / Parent Signature Date Patient / Parent Name (please print)

atient Acknowledgement for dependant family members.
lease Print Patient Names

_____ _____ _____

Patient Name (please print) Patient Name (please print) Patient Name (please print)

For Office Use Only
Patient Refused to Sign

The following circumstances prohibited the patient from signing the Acknowledgment:

_____

An emergency situation prevented the patient from signing the Acknowledgment.

_____ _____ _____

Office Personnel (signature) Date Office Personnel (print name)

Patient Consent

Please sign this form below under the heading "Consent" to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosure of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

X_____ _____ X_____

Patient / Parent Signature Date Patient / Parent Name (please print)

Consent for dependant family members –Patient Names Please Print

_____ _____ _____

Patient Name (please print) Patient Name (please print) Patient Name (please print)

DENTAL TREATMENT CONSENT FORM

Please read and initial the items checked below and read and sign the section at the bottom of form.

Patient Name_____

☒ **1. WORK TO BE DONE**

I understand that I am having the following work done: Fillings_____ Bridges_____ Crowns_____ Extractions_____ Impacted teeth removed_____ General Anesthesia_____ Root Canals_____ Other Prophy_____

(Initials_____)

☐ **2. DRUGS AND MEDICATIONS**

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction.)

(Initials_____)

☐ **3. CHANGES IN TREATMENT PLAN**

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

(Initials_____)

☐ **4. REMOVAL OF TEETH**

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth_____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

(Initials_____)

☐ **5. CROWN, BRIDGES AND CAPS**

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation.

(Initials_____)

☐ **6. DENTURES, COMPLETE OR PARTIAL**

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

(Initials_____)

☐ **7. ENDODONTIC TREATMENT (ROOT CANAL)**

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy.)

(Initials_____)

☐ **8. PERIODONTAL LOSS (TISSUE AND BONE)**

I understand that I have a serious condition, causing gum and bone infection or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

(Initials_____)

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of patient_____ Date_____

Signature of Parent/Guardian if patient is a minor_____ Date_____

FINANCIAL POLICY

ESTIMATED SERVICES

Your estimated dental treatment plan will be based on your initial examination. Your plan will be derived from the available diagnostic aids and will be an estimation of the procedures necessary for the improvement of your dental health. Since not all conditions may be clearly evident during your initial examination, any unforeseen problems may require an adjustment to your treatment plan and payment arrangements. You will be consulted before any additional treatment is undertaken. This estimate will be honored provided treatment is completed within six months of the date of consultation.

OFFICE HOURS

Our office hours are Monday 9am-5:30pm, Tuesday -Thursday 9am-6pm, and Friday 9am-3pm.

APPOINTMENTS

We realize that your time is valuable, and in order to minimize waiting, we reserve appointment times especially for you. We ask that you show us the same courtesy. Each time we make an appointment, you will receive a card showing the date and time of your appointment. If you are unable to keep your appointment, please notify the office at least *48 hours* prior to your appointment. Larger case appointments require five business days notice. ***Please remember, we do not take cancellations after business hours.***

INSURANCE

Much confusion exists regarding dental payments. Your dental insurance plan is a contract between ***you and your insurance company***. Because the terms of all plans and policies differ, you should be familiar with the specific terms of your policy. Although the filing of insurance claims is a courtesy that we extend to our patients to facilitate their prompt reimbursement, please understand that the payment of all fees is *your* responsibility.

Therefore, the payment of fees is an obligation of the patient, *whether or not* the insurance company ultimately reimburses the patient. We will, of course, use all our resources to assist you in seeking reimbursement to the full extent permitted under your policy. Our office does participate with most PPO insurance plans. Therefore we do accept assignment of benefits. Our patients are, however, responsible for any estimated co-payments and amounts not covered by their insurance plan at the time services are rendered.

FINANCIAL

We expect payment in full at the time of service unless a formal payment arrangement has been established. Patients with dental insurance will be asked to make their co-payments at the time of service. Accounts without a payment agreement that have a balance over 60 days will be considered overdue. These accounts are due immediately, regardless of insurance status. Returned checks will be subject to an administration fee of $30. The patient, parent and/or guardian shall be responsible for payment of all procedures performed in this office, including any treatment not covered by any dental insurance. Our surgery cancellation policy will be reviewed at the time of your treatment consultation.

CONSENT

I certify that I have read, understood and agree to these terms and that I have been given a copy of this financial policy.

Signature of patient_____ Date_____

Signature of Parent/Guardian if patient is a minor_____ Date_____