Welcome. We're glad you're here.

To better serve you, please take just a couple of minutes to answer the following questions. Thanks!

desert creek dental

Please check any of the following problems that apply to you:

✔

- ○ Sensitivity (hot, cold, or sweet).
  If so, which teeth? _____
- ○ Dental fear or anxiety
- ○ Headaches, earaches, neck pain
- ○ Teeth or fillings breaking
- ○ Grinding or clenching teeth
- ○ Bleeding, swollen, or irritated gums
- ○ Loose, tipped or shifting teeth
- ○ Bad breath

Do you have or have you had any of the following?

- ○ Dentures
- ○ Partial dentures
- ○ Periodontal (gum) treatments

Please share the following approximate dates:

Your last cleaning _____

Your last oral cancer screening _____

Your last complete x-rays _____

Who was your previous dentist?

Name: _____

City: _____ State: _____

Phone: _____

What are the most important things to you about your smile and dental health?

What is the most important thing to you about your dental visit today?

Do you smoke or use chewing tobacco?

○ Yes ○ No

If yes, how much? And, for how long?

If you could change your smile, would you:
(please check all that apply)

- ○ Make your teeth whiter
- ○ Make your teeth straighter
- ○ Close spaces between teeth
- ○ Replace black metal fillings with tooth-colored restorations
- ○ Repair chipped teeth
- ○ Replace missing teeth
- ○ Replace old crowns that don't match
- ○ Have a smile makeover

On a scale of 1 to 5, with 5 being the highest rating:
(please check the number that best applies)

How important is your dental health to you?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

How would you rate your current dental health?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Where do you want your dental health to be?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Why did you leave your previous dentist?

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WELCOME

The benefits of a happy, healthy smile are immeasurable!
Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely.
Your answers are for our records only and will be kept confidential subject to applicable laws.
The better we communicate, the better we can care for you.

1 ABOUT YOU

Name _____

Preferred Name _____ ❑ Male ❑ Female

❑ Single ❑ Married ❑ Other

Birthdate ___/___/___ Age _____ SS # ___-___-___

Address _____

City _____ State _____ Zip _____

Email _____

May we contact you via email? ❑ Yes ❑ No

Home # _____ Mobile # _____

Other family members seen by us: _____

How did you hear about us? Friend/Family: _____

❑ Facebook ❑ Google ❑ Insurance Company Referral

❑ Other (please specify _____

Employer _____ Employer Ph # _____

Employer Address _____

How long employed there? _____

2 ACCOUNT INFO

PERSON RESPONSIBLE FOR ACCOUNT
(if under 18)

Name _____ Relation _____

Home # _____ Work # _____

Mobile # _____ Birthdate ___/___/___

Email _____

Billing Address _____

City _____ State _____ Zip _____

3 SPOUSE INFO

Name _____

Home # _____ Work # _____

Mobile # _____ Birthdate ___/___/___

4 DENTAL INSURANCE

Provider Name _____

Provider Address _____

City _____ State _____ Zip _____

Group # _____ ID # _____

Insured's Name _____

Relation to you _____ Insured's SSN # _____

Insured's Birthdate _____ Insured's Ph # _____

Insured's Employer _____

SECONDARY INSURANCE

Provider Name _____

Provider Address _____

City _____ State _____ Zip _____

Group # _____ ID # _____

Insured's Name _____

Relation to you _____ Insured's SSN # _____

Insured's Birthdate _____ Insured's Ph # _____

Insured's Employer _____

5a MEDICAL

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name _____

Phone # _____ Last visit date: _____

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain _____

Pharmacy: _____ Phone: _____ Location _____

IN THE EVENT OF AN EMERGENCY, WHO SHOULD WE CONTACT?

Name _____ Relation _____

Home # _____ Work # _____

Thank you for filling out this form completely. It will allow us to serve you more effectively. If you have a question at any time, or need help completing this form, please ask us. We are happy to help.

5b MEDICAL HISTORY

Name _____

Your current physical condition ❑ Good ❑ Fair ❑ Poor

Do you smoke or use tobacco in any form? ❑ Yes ❑ No

Are you taking any prescription/over-the-counter or herbal supplement drugs? ❑ Yes ❑ No

Please list each one _____

_____

_____

_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

(please circle yes or no)

Yes	No	Abnormal Bleeding	Yes	No	Herpes/Fever Blisters
Yes	No	Alcohol / Drug Abuse	Yes	No	High Blood Pressure
Yes	No	Anemia	Yes	No	HIV+ / AIDS
Yes	No	Arthritis	Yes	No	Hospitalized
Yes	No	Artificial Bones, Joints, or Valves			for any reason
			Yes	No	Kidney Problems
Yes	No	Asthma	Yes	No	Liver Disease
Yes	No	Blood Transfusion	Yes	No	Low Blood Pressure
Yes	No	Cancer/Chemotherapy	Yes	No	Lupus
Yes	No	Colitis	Yes	No	Mitral Valve Prolapse
Yes	No	Congenital Heart Defect	Yes	No	Pacemaker
Yes	No	Diabetes	Yes	No	Psychiatric Problems
Yes	No	Difficulty Breathing	Yes	No	Radiation Treatment
Yes	No	Emphysema	Yes	No	Rheumatic/Scarlet Fever
Yes	No	Epilepsy	Yes	No	Seizures
Yes	No	Fainting Spells	Yes	No	Shingles
Yes	No	Frequent Headaches	Yes	No	Sickle Cell Disease
Yes	No	Glaucoma	Yes	No	Sinus Problems
Yes	No	Hay Fever	Yes	No	Sleep Disorder
Yes	No	Heart Attack	Yes	No	Stroke
Yes	No	Heart Murmur	Yes	No	Thyroid Problems
Yes	No	Heart Surgery	Yes	No	Tuberculosis (TB)
Yes	No	Hemophilia	Yes	No	Ulcers
Yes	No	Hepatitis A / B / C	Yes	No	Venereal Disease

Please list any medical condition(s) that you have ever had

_____

_____

_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Yes	No	Aspirin	Yes	No	Erythromycin	Yes	No	Penicillin
Yes	No	Codeine	Yes	No	Jewelry/Metals	Yes	No	Tetracycline
			Yes	No	Latex	Yes	No	Other
			Yes	No	Dental Anesthetics			

Please list any other drugs/materials that you are allergic to:

_____

_____

FOR WOMEN ONLY

Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Week # _____

Are you nursing? ❑ Yes ❑ No

Revised 02/2017

6 HISTORY

Has your doctor told you that you require antibiotics before dental treatment? ❑ Yes ❑ No

Do you or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Have you ever had a joint replacement? ❑ Yes ❑ No

Do you experience dry mouth? ❑ Yes ❑ No

Do you have sleep apnea? ❑ Yes ❑ No

Have you had a sleep apnea study in the last 5 years? ❑ Yes ❑ No

Have you ever worn a CPAP? ❑ Yes ❑ No

Do you snore? ❑ Yes ❑ No

Your current dental health is ❑ Good ❑ Fair ❑ Poor

Do you like your smile? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑No

How many times a day do you clean between your teeth?_____

❑ Floss ❑ Waterpik ❑ Other

How many times a day do you brush? _____

Type of toothbrush bristles? ❑ Hard ❑ Medium ❑ Soft

What type of toothbrush do you use? ❑ Manual ❑ Electric

If electric, which brand? _____

Would you like to learn more about sedation options available?

❑ Yes ❑ No

7 DISCLAIMER

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature Date

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

Our office is HIPAA compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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Informed General Consent

EMERGENCY DENTAL CARE: Emergency dental treatment is intended to provide relief of severe pain and infection for individuals in acute need. You, as a patient of record, have access to a 24 hour dental emergency service. There may be a charge associated with this service.

CONSENT TO DENTAL PROCEDURES: As a patient you will have access to current and complete information about your condition and will, unless otherwise specified, receive continuity of treatment, which may include treatment provided by other dentists, be provided an estimate of the cost, and receive dental care according to a properly sequenced plan of treatment. Before receiving treatment you should ask the dentist about the procedure(s) that he/she recommends you undergo, and ask any questions you may have before you decide whether or not to give your consent for the procedure (s) to be done. All dental procedures may involve risks of unsuccessful results and complications, and no guarantee is made as to result or cure. You have the right at all times to be informed of any such risks as well as the nature of the procedure, the expected benefit, the availability of alternative methods of treatment, and the risks of no treatment. You have the right to consent to or refuse any proposed procedure at any time prior to its performance.

X-RAYS: Dental radiographic images will be made as necessary and appropriate for examinations, diagnosis, consultation, and treatment.

FINANCIAL RESPONSIBILITY: You will be charged for treatment according to the fee schedule in effect. Fees may vary depending on the dental care provider. A fee estimate will be provided prior to beginning treatment and you must be prepared to pay for services as they are performed. Fees are collected in full at the completion of a procedure unless other arrangements are made in writing. If for some reason you do not pay in full for the treatment provided that day. Any balance remaining on your account ninety days after treatment will result in your account being turned over to a collection agency. You will be responsible for any collection or legal fees which may be incurred as a result of your failure to pay for your dental work.

DENTAL INSURANCE: Desert Creek Dental, will assist you with dental insurance by completing the claim forms and returning them to you so that you can be reimbursed by the insurance carrier. Please check with our insurance coordinator or other front desk personnel to determine which insurance plans can be accepted for direct reimbursement to the office.

DENTAL MEDICAL RECORDS: The dental medical record, radiographic images, photographs, videos, models and other diagnostic aids relating to your treatment arc the property of the office. You have the right to inspect such materials and to request a copy of your dental medical records and radiographic images. A fee of S25.00 may be required for copying these items. You may also request to have your dental radiographic images sent to another health care provider by signing a Release of Information form. The office also complies with requirements of the Health Insurance Portability and Accountability Act (HIPAA) and you will receive separate information, forms and consents in that regard. In addition, your dental medical record may be used for instructional purposes and if it is, your identity will not be disclosed to individuals not involved in your care and treatment.

KEEPING YOUR APPOINTMENTS: It is important for you to be on time for your appointments. If you find that you are unable to keep an appointment, you agree to notify the dentist or the appointment secretary at least 24 hours in advance. A total of two cancellations without 24 hour notice, more than two missed appointments, or repeated unsuccessful attempts to arrange an appointment may result in the discontinuance of further treatment at Desert Creek Dental.

DISCONTINUANCE OF TREATMENT: Desert Creek Dental, reserves the right to discontinue dental treatment whenever it is considered advisable and in the best interest of you and the office. Should treatment be terminated, any remaining credit balance for services not yet provided will be refunded to you. If you have complaints which cannot be resolved at the management level, you have access to the Office Administrator.

I do hereby acknowledge, agree and give my voluntary consent for treatment provided through Desert Creek Dental, as may be deemed necessary or desirable by my treating dentist and their assistants. This Authorization includes, but is not limited to, routine diagnostic procedures, laboratory tests, and x-rays. 1 understand that my treatment may include a variety of interventions. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me as to results of examination and treatment received at the office. I acknowledge that my care is under the direction of my treating professional(s) and I represent that I will follow the instructions of my professional(s) in the provision of said care.

Your signature on this form certifies that you have read and understand the information provided on the form, that you have received a copy, and that you accept dental care and treatment under the described terms and conditions.

Date: _____ Signature: _____