Patient Information

Date:_____ Patients Name _____
Last First Middle

Address _____
Street City State Zip

Cell Phone (___) _____ Social Security # ___-___-___ Drivers License # _____ E-mail _____

Birthdate___ / ___ / ___ If patient is a minor, give parent's/guardian's name_____

Occupation _____ Student Status _____ School Name _____

Name of nearest relative not living with you _____ Cell Phone (___) _____ Relationship _____

Complete Address _____ Phone (___) _____

Emergency Contact _____ Phone (___) _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Name _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone (___) _____ Work Phone (___) _____

Previous address (if less than 3 years) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Employer Address _____

Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____

Insurance Co. Address _____ Ph # _____

Is policy connected with your union? Yes_____ No_____ Name of Union _____ Local No. _____

Do you have dual coverage? Yes_____ No_____ If yes: Please complete the following secondary insurance information.

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Co. _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Ph # _____

Insured's Employer _____ Ph # _____

Oral Information

Do your gums bleed when you brush? Yes ___ No ___

Are your teeth sensitive to heat or cold? Yes ___ No ___ Pressure Yes ___ No ___ Sweets Yes ___ No ___

Do you grind or clench your teeth? Yes ___ No ___

Do you have any fear of dental work? Yes ___ No ___

Date of last dental examination _____ What was done at that time? _____

Main concern or current dental problem? _____

What changes to the appearance of your teeth would you like to make? _____

HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Hepatitis Type_____	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Swelling of Feet or Ankles	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	HIV Positive	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Women:	
Emphysema	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Are you pregnant?	☐ Yes ☐ No
Do you wear contact lenses?	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Due date_____	
		Radiation Treatment	☐ Yes ☐ No	Are you nursing?	☐ Yes ☐ No

Surgeries: _____

MEDICATIONS

List medications you are currently taking:

_____

_____

Have you ever taken Bisphosphonates (Fosamax®) ☐ Yes ☐ No

Have you ever taken Redux? ☐ Yes ☐ No

When were your last dental xrays? _____

ALLERGIES

☐ Aspirin
☐ Barbiturates (Sleeping pills)
☐ Codeine
☐ Iodine
☐ Latex
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Other _____

_____

DATE	PATIENT'S/PARENT'S SIGNATURE	P/BP	DOCTOR'S SIGNATURE

UPDATES (to be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

Patient's Signature _____ Date: _____

Doctor's Signature _____ Date: _____

Has there been any changes in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

Patient's Signature _____ Date: _____

Doctor's Signature _____ Date: _____

Office Policy

Dear Patients,

Welcome to our office. We will do our best to make your visit as comfortable as possible. We are pleased that you have chosen our office for your dental health care needs. We strive to provide our patients with high quality comprehensive dental care at a reasonable fee.

On your first visit expect:
A thorough examination and review of your oral health including necessary x-rays. Teeth cleanings are schedule on a different day.

Your recommended treatment will be explained and you will receive an estimate of your cost according to your particular insurance plan. Treatment rendered and not paid by your insurance company, will be your responsibility to pay.

Please help us to serve all our patients by keeping your appointment. Every time an appointment is made a certain amount of time is reserved special just for you. If you cancel with less than 48-hours notice, we do not have the opportunity to offer your appointment to another patient in need. There will be a charge of $35 fee, per hour set aside for you, if the appropriate amount of notice is not given.

We require a deposit be made on all future treatment appointments.

We accept cash, check, debit card, Visa, MasterCard, and Internet Free Financing (information available at front desk). We offer variety of payment options, such as, 5% prepayment courtesy and In Office Plan (ask for details). Should financial arrangement be necessary, they must be made *prior* to dental treatment. Payment is due as dental treatment is rendered, unless *prior* financial arrangements have been approved. Returned checks (non sufficient funds, stop payment, etc.) will be subject to a fee of $35 in addition to the amount of the check written and will be due immediately. There is a $15 late fee for any balance past due 30 days or more. It will be charged monthly until balance due is paid in full. If our office is unable to collect any balance due within 90 days your account will be sent to collections. A $100.00 collection fee will be added to the balance due and it will be listed as a collection amount with the consumer credit reporting bureaus. If balance due is still not paid in full further action will be taken.

X-rays will be released upon signed authorization and a $35.00 duplication fee (per patient) will be charged. We are required by law to have a copy of x-rays in the chart.

I have read and understand the above policy and agree to its terms.

Signature_____ Date_____

Copper Canyon Smiles

For office communication purposes, we kindly request that you fill out the information requested below. Your information will be kept confidential and will only be used for confirmation of appointments and communication purposes between Copper Canyon Smiles and you.

Patient Name: _____

Cell Phone Number: _____

E-Mail Address: _____

DENTAL TREATMENT CONSENT 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_____ Exam + X-Rays_____

(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 & BONE)**

I understand that I have a serious condition, causing gum and bone inflammation 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_____

Doctor Signature_____ Assistant_____ Date_____

PATIENT ACKNOWLEDGEMENT OF

RECEIPT OF NOTICE OF PRIVACY PRACTICES

Date:_____

Please read our notice of Privacy Practices .You have the right to refuse to sign this Acknowledgement

I,_____, have received a copy of this

Office's NOTICE OF PRIVACY PRACTICES as required by federal law.

_____

Print Patient's Name

_____

Patient's Signature

Notice about Dental Insurances:

Because Insurance policies vary, we can only estimate your dental coverage due to complexities of insurance contracts. Ours fees generally, but not necessarily, fall within the usual and customary fee structure determined by your dental carrier. **Not all dental services are covered by all dental plans. Your estimated patient portion (co-pay) is due on the day of scheduling dental services**. Your estimated portion is based on information given to us by your insurance carrier. However, we may need to send you a statement if the estimated differs from the actual insurance payment. We will bill your insurance company and allow them 60 days to render payment. After 60 days, you will be responsible for the entire balance.

Print Patient's Name_____

Patient's Signature_____