

# North Valley Family Dentistry

We would like to get to know you better!

Date \_\_\_\_\_

Patient Name \_\_\_\_\_  Male  Female  Single  Married  Other

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Referred by \_\_\_\_\_

For Insurance Purposes:

Name of Insurance Carrier \_\_\_\_\_ Group Number \_\_\_\_\_

Phone Number \_\_\_\_\_

Name of Cardholder \_\_\_\_\_ Cardholder's Date of Birth \_\_\_\_\_

Cardholder's Social Security Number \_\_\_\_\_ Cardholder's Employer \_\_\_\_\_

## **Dental History**

In the last several months

have you experienced any of the following:

Sensitivity to:

Heat?  Yes  No

Cold?  Yes  No

Sweets?  Yes  No

Biting?  Yes  No

Food Impaction?  Yes  No

Bleeding, sore gums?  Yes  No

Unpleasant taste or odor?  Yes  No

Loose teeth/broken fillings?  Yes  No

Clicking of the jaw?  Yes  No

Pain (joints,ear,face)?  Yes  No

Difficulty opening or closing?  Yes  No

Difficulty chewing?  Yes  No

Grinding or clenching?  Yes  No

Bleeding, swollen/irritated gums?  Yes  No

Loose, tipped or shifting teeth?  Yes  No

Bad breath?  Yes  No

Have you ever had a reaction to a local anesthetic?  Yes  No

Are you dissatisfied with your teeth and their appearance?  Yes  No

Do you get frustrated b/c you always have something to be treated when you visit the dentist?  Yes  No

Have you ever had teeth removed?  Yes  No

How long have these teeth been missing? \_\_\_\_\_

Do you have any dental fears?  Yes  No

Are you concerned about the finances required to return your teeth to excellent dental health?  Yes  No

What is your present dental problem? \_\_\_\_\_

\_\_\_\_\_

**Do you have/had any of the following?**

-Dentures  Yes  No

-Partial Dentures  Yes  No

-Braces  Yes  No

-Periodontal treatments  Yes  No

**Please share the following dates:**

-Your last cleaning \_\_\_\_\_/\_\_\_\_\_

-Your last oral cancer screen \_\_\_\_\_/\_\_\_\_\_

-Your last complete x-rays \_\_\_\_\_/\_\_\_\_\_

**Name of Previous Dentist** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_

**Phone Number** \_\_\_\_\_

**If you could whiten your teeth for a cost anyone could afford, would you do it?** \_\_\_\_\_

Do you use chewing tobacco?  Yes  No

Do you smoke?  Yes  No

How much? \_\_\_\_\_ For how long? \_\_\_\_\_

**If I could change my smile, I would:**

-Make them brighter

-Make them straighter

-Close spaces

-Replace black metal fillings

with tooth-colored fillings

-Repair chipped teeth

-Replace missing teeth

-Replace missing crowns

that don't match

-Have a smile makeover

**On a scale of 1-10, with 10 being the highest rating:**

-How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

-Where would you rate your dental health now?

1 2 3 4 5 6 7 8 9 10

**Why did you leave your previous dentist?**

**Health History**

Do you have any general health problems?  Yes  No

If so, please specify \_\_\_\_\_

Are you currently under a physician's care?  Yes  No

Reason \_\_\_\_\_

Any medications? \_\_\_\_\_

Have you had surgery?  Yes  No

If so, please specify \_\_\_\_\_

To the best of your knowledge, are you, or have you ever been  
Afflicted with

Sinus problems  Yes  No

Headaches  Yes  No

Stroke  Yes  No

Dizziness/fainting  Yes  No

Epilepsy  Yes  No

Asthma  Yes  No

Persistent cough  Yes  No

Allergies  Yes  No

Material allergies (latex, metal, chemicals)  Yes  No

Food Allergies  Yes  No

Drug Allergies \_\_\_\_\_

Osteoporosis  Yes  No

Diabetes  Yes  No

Tobacco habit  Yes  No

Blood disease  Yes  No

Heart Problems  Yes  No

Artificial heart valve  Yes  No

Heart murmur  Yes  No

Mitral valve prolapse  Yes  No

High blood pressure  Yes  No

Pacemaker  Yes  No

Kidney problems  Yes  No

Liver disease  Yes  No

Arthritis, Rheumatism  Yes  No

Artificial joints  Yes  No

Hepatitis  Yes  No

AIDS/HIV  Yes  No

Stomach problems  Yes  No

Cancer  Yes  No

Chemotherapy  Yes  No

Radiation treatment  Yes  No

Pregnancy/Due Date \_\_\_\_\_  Yes  No

## **Consent for Treatment**

I understand the preceding medical history information is necessary to provide me with dental treatment in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, which may release such information to you. I will notify the doctor of any change in my health history or medication.

I hereby authorize the doctors, or designated staff, to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.

Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by the doctor, and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Photo consent: If any before/after photos are taken of dental work performed, I give the doctor permission to use photos for educational purposes and lecture presentations.

### **Financial Policy**

1. **If you have dental insurance** that is currently of effect, we may begin treatment against anticipated insurance benefits.

Remember, insurance is a contract between you and your insurance carrier. Some insurance companies pay more and some pay less. **We will estimate your portion of payment, which will be due at the time of treatment. Any balance that is outstanding after 60 days is entirely your responsibility.**

2. **If you do not have dental insurance**, payment is due for services as they are rendered.

We accept all major credit cards as well as checks and cash. We do NOT extend credit. Instead, we suggest private financing. We also have financing available through Care Credit and ChaseHealthAdvance. Our financial Coordinator would be happy to give you more information on this option. We do offer a 5% - 10% cash/check discount.

I understand the consent for treatment and the financial policy of this office regarding "If you have dental insurance"/ "If you do not have dental insurance." I further agree to pay all finance charges, collection cost, attorneys fees and any other cost that may be incurred to enforce collection of any amount outstanding. A late fee of \$25 will be added after a balance is past 90 days due. I agree to the terms of this financial policy. I will pay by:

Check \_\_\_\_\_ Cash \_\_\_\_\_ Credit Card \_\_\_\_\_ Other \_\_\_\_\_  
(\$25 charge for returned checks)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## **CANCELLATION / NO SHOW POLICY**

In order to ensure that quality patient care is maintained and all patients can be accommodated it is important that you notify North Valley Family Dentistry with your intentions to cancel or change your appointment at least **twenty-four business hours (24)** prior to your reserved appointment by calling (623) 551-9200. If you have an appointment reserved on Monday, please call the office on the preceding Thursday (one business day) to cancel or change that appointment.

**If no call is received within this time period you will be considered a “No Show” and a charge will be assessed at \$50.00**

Please take the time and consideration needed to provide the proper notification of your intention to cancel your visit with your Provider.

We understand there may be times you will miss an appointment due to family emergency or obligations and we will take these situations into account, however, we strongly encourage you to inform us within 1 business day prior to your reserved appointment so that we can accommodate another patient in that time slot.

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I, \_\_\_\_\_ have read and had the above policy explained to me. I agree to abide by the request to notify the practice at least one business day in advance of a reserved appointment of my intention to cancel or change my appointment. I understand this assessment will not be charged to my insurance carrier and I will be responsible for paying for it.

I also understand that with three (3) or more missed appointments, North Valley Family Dentistry has the right to discharge me from the practice. If discharged, North Valley Family Dentistry will notify me in writing regular mail.

I have read the above information, and I agree to these terms:

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Relationship to Patient

**Erica Elannan, D.D.S.**