Welcome, we're glad you've chosen to be our patient!

Let's get acquainted.....

Hobbies & Interests _____

Family? Kids? (Ages) _____

Business/Occupation _____

Reason(s) for today's visit _____

Are you preparing for a special occasion? Wedding? Reunion? Vacation? When? _____

_____

PATIENT INFORMATION

CONFIDENTIAL

(PLEASE PRINT) Date _____

Name _____ Birth Date _____ Phone _____

Address _____ City _____ State _____ Zip _____

Email _____

Check Appropriate Box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____

Employer _____ Work Phone _____

If Patient is a Student, Name of School/College _____ City _____ State _____

Emergency Contact _____ Phone _____

How were You Referred to Our Office? _____

INSURANCE INFORMATION

Name of Insured _____ Ins Phone _____

Birth Date _____ Social Security Number _____

Name of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ❑ YES ❑ NO IF YES, COMPLETE THE FOLLOWING

Name of Insured _____ Ins Phone _____

Birth Date _____ Social Security Number _____

Name of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____

DENTAL HISTORY

In the last several months have you experienced any of the following:

Sensitivity to Heat? ❑ Yes ❑ No
Sensitivity to Cold? ❑ Yes ❑ No
Sensitivity to Sweets? ❑ Yes ❑ No
Sensitivity to 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 _____
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 ❑
-Fresher Breath ❑
-Do your gums bleed upon Brushing? ❑ Yes ❑ No
-Upon Flossing? ❑ Yes ❑ No
-Have you been diagnosed with gum disease? ❑ Yes ❑ No

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 _____
List Your Current 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 Headaches ❑ Yes ❑ No
Stroke Dizziness/fainting 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
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

DENTAL PATIENT INFORMED CONSENT

THE FOLLOWING IS A LIST OF COMMON RISKS AND/OR COMPLICATIONS, WHICH MAY OCCUR DURING AND/OR AFTER DENTAL TREATMENT AND/OR DENTAL SURGERY. THIS LIST DOES NOT ITEMIZE EVERY POSSIBLE RISK AND THE PATIENT OR GUARDIAN IS HEREBY ADVISED TO SEEK A SECOND OPINION REGARDING ANY DENTAL TREATMENT, WHICH THEY DO NOT FULLY UNDERSTAND. PLEASE READ THIS FORM CAREFULLY AND ASK ANY QUESTIONS THAT YOU HAVE CONCERNING THE TREATMENT OF YOURSELF OR YOUR DEPENDENT. YOU SHOULD UNDERSTAND THAT SINCE DENTISTRY IS NOT AN EXACT SCIENCE, NO SPECIFIC RESULTS ARE PROMISED, OR GUARANTEED. ALTHOUGH THE STAFF AT NORTH VALLEY FAMILY DENTISTRY DOES NOT EXPECT YOU TO SUFFER UNNECESSARY COMPLICATIONS, YOU ARE HEREBY ADVISED THAT IT IS A POSSIBILITY. YOUR SIGNATURE ON THIS FORM IMPLIES THAT YOU UNDERSTAND, TO THE BEST OF YOUR ABILITY, AND ACCEPT THE RISKS, AND/OR COMPLICATIONS WHICH MAY OCCUR DURING YOUR DENTAL TREATMENT. YOU ACKNOWLEDGE THAT THE RISKS HAVE BEEN ADEQUATELY EXPLAINED TO YOU IN A MANNER WHICH YOU UNDERSTAND, AND THAT YOU REALIZE THE FOLLOWING LIST DOES NOT REPRESENT A COMPLETE EXPLANATION OF EVERY RISK YOU MAY ENCOUNTER IN THIS OR ANY OTHER DENTAL OFFICE.

1. X-rays are a form of radiation and should be avoided during pregnancy. If you ever visit this office while pregnant or suspicious of a pregnancy, it is YOUR responsibility to notify North Valley Family Dentistry and REFUSE X-RAYS. Since most dental procedures are diagnosed and treated with the aid of x-rays, you must understand that we will require you to receive x-rays for most of the procedures we provide. A lead apron has been provided for your use and protection.
2. The administration of local anesthetic will make you numb for 1 to 6 hours. You should bite carefully to prevent injuring yourself during this time. It will also leave you with soreness or discomfort at the injection for several minutes to several days. If this is unacceptable, then you should request that minor treatment be performed without anesthetic, or schedule your appointment for a time when this discomfort is not going to be a problem.
3. A routine injection may injure or sever a nerve, leaving you with long-term or permanent anesthesia or parathesia. A routine injection may also puncture a blood vessel, causing hemorrhage, hematoma, or severe swelling. If this occurs, call our office. Further treatment may be necessary from North Valley Family Dentistry or a dentist, ER or Urgent Care Facility of their choice.
4. Extraction of an erupted or impacted tooth or root tip may result in the same symptoms as described in item #3. Extraction of an upper tooth may result in loss of all or part of the tooth into a sinus cavity requiring further surgery from North Valley Family Dentistry or a dentist of their choice. It is possible for an upper tooth to be successfully extracted while still opening an oral/antral fistula into a sinus. If your sinus is exposed, you will likely require further surgery from North Valley Family Dentistry or a dentist of their choice. In the event either of these surgical procedures is required, you should avoid sucking on straws or blowing up balloons (or similar activities) for at least 6-8 weeks. If you feel unexplained air pressure leaking between your mouth and sinuses after an upper extraction, YOU are expected to call this office.
5. Teeth are often filled or crowned with gold, silver, porcelain or other substances, which conduct hot, cold and other stimuli extremely well. Most teeth are sensitive from 3 days to 3 weeks: however, some teeth are sensitive much longer or perhaps permanently. If your sensitivity persists, you will likely require pulpal treatment or root canal therapy by North Valley Family Dentistry or a dentist of their choice. This sort of sensitivity generally results from large carious lesions, large restorations, large immature pupals, hairline cracks or reduction for fixed prosthetics: but HAS ALSO BEEN SHOWN TO OCCUR FOR NO KNOWN REASON.
6. Teeth that are crowned are often teeth, which have fractured or have been repeatedly filled. Even a perfectly healthy tooth must be substantially reduced to receive a crown. This is particularly true with tipped, crooked, or mal-occluded teeth. This reduction may cause sensitivity and can lead to future pupal treatment or root canal therapy. Teeth, which have been crowned, NEVER have perfect margins. As you age or your gingival tissue recedes, the margin is exposed and may cause the tooth to be more sensitive. In some instances, the pulp must be treated and/or the crown re placed. Porcelain behaves like glass and can easily fracture by hard foods or a blow to the mouth. Some long fixed bridges flex enough to fracture the porcelain covering. Fractured porcelain prosthetics are seldom repairable. North Valley Family Dentistry does not accept responsibility for fractured porcelain since it is out of their control. The patient is, however, advised that the metal jacket coping adequately protects the tooth with or without the porcelain covering.

7. Pulpal treatment or root canal therapy involves the placement of tiny fragile instruments into a tiny, often restricted canal. These instruments can, and do, occasionally fracture inside the tooth. If this occurs, your attending dentist at North Valley Family Dentistry may attempt to remove the instrument or refer you to an Endodontist to have it removed. If it is not or cannot be retrieved, we will advise you of its presence. In many cases, the fractured piece actually seals the canal, so no further treatment is needed. While fitting a root canal, it is possible to extrude gutta percha or root canal cement beyond the apex of the tooth. Even during routine canal therapy, it is possible for painful symptoms persist. If symptoms persist following any of these circumstances you will likely require a surgical apico-ectomy and/or retrofill that may be performed by an Endodontist or dentist of their choice. If the symptoms are still not relieved, then it is likely that the tooth will require extraction.
8. Removable dentures and partial dentures are plastic and/or metal appliances that at best, are uncomfortable, clumsy and feel loose. Because they are not cemented in place, they rub your gingival tissue and cause frequent sore spots. Clasps on partial dentures rub on adjacent teeth and cause scarring and lateral torque. A partial clasp can cause food traps, periodontal disease, tooth decay and loss of adjacent teeth and cause scarring and lateral torque. You are advised to keep these appliances as clean as possible and have them examined regularly in this office
9. Crowns, fixed bridges, fillings, dentures, root canals and most other dental treatments are the dentist's attempt to correct or prevent dental disease. These forms of treatment are not intended to substitute for healthy teeth but rather substitute for unhealthy and/or missing teeth. Dental treatment is not always successful at first. Some teeth or appliances need to be retreated or treated differently and SOME DO NOT RESPOND FAVORABLY TO ANY TREATMENT and are eventually extracted. Dental treatment may succeed at first and then suffer recurrent caries, fractures, abscess or pain in the future. You should visit this office no less then once per year to give North Valley Family Dentistry the greatest possibility of serving you. YOU are encouraged to call if you ever have questions or complaints about your treatment. You will find the staff eager to make you comfortable.
10. Some patients present to the dental office with compromising health conditions. A history of A.I.D.S., heart disease, rheumatic fever, bleeding disorders, liver disease, hepatitis, kidney disease, lung disease; or an allergy of sensitivity to penicillin, erythromycin, codeine, Percodan, Hycodaphen, aspirin, Tylenol, Empirin, Xylocaine, Carbocaine, or Novocaine, may qualify you as an unjustifiable risk for this office. YOU are expected to circle any of the above conditions which you are EVEN SUSPECTED of having and notify North Valley Family Dentistry IN PERSON. FAILURE TO DO SO COULD RESULT IN SERIOUS INJURY OR DEATH. If you have a history of heart disease or other serious ailment, you will be required to have your physician consult with North Valley Family Dentistry to determine whether or not you can be safely treated in this office. Even when precautions are taken, it is possible that you could suffer an exacerbation of your condition and/or any of its related complications.
11. Prescribing medications is routine in a dental practice. Antibiotics are prescribed for the control of infection; narcotic and non-narcotic analgesics are prescribed for the control of pain. Sedative/hypnotics are sometimes prescribed for the control of anxiety. Fluoride tablets and rinses are prescribed for the caries reduction. MANY OF THE PRESCRIPTIONS WRITTEN IN THIS OFFICE CAN AND DO REACT UNFAVORABLY WITH MANY OTHER MEDICATIONS. If you are taking other medications at the time you are offered a prescription, YOU are expected to remind North Valley Family Dentistry of all medications you are then using. If you are using or abusing controlled substances, marijuana, narcotics or any other drug (s), YOU are expected to give this information to North Valley Family Dentistry each time you receive a prescription from this office, so that we may substitute the medication or alter its dosage appropriately. FAILURE TO DO SO COULD RESULT IN DEATH OR SERIOUS INJURY. Antibiotics often render birth control pills ineffective; appropriate precautions must be taken during antibiotic therapy.

I DO HEREBY ACKNOWLEDGE THAT I HAVE BEEN INFORMED, TO MY SATISFACTION, OF THE RISKS AND/OR COMPLICATIONS OF THE DENTAL TREATMENT WHICH NORTH VALLEY FAMILY DENTISTRY AND/OR ASSOCIATES IS TO PROVIDE FOR ME (OR MY DEPENDENTS).

Signature of patient or guardian:_____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 **forty eight hours (48)** 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.

Please be aware there is a $25 FEE for any appointment cancelled less than 48 hours in advance and for no shows. Our Dentist and Hygienist have set their time aside for especially for you.

A $50 FEE will apply for 2+ hour appointments.

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.

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

NORTH VALLEY FAMILY DENTISTRY
HIPPA PRIVACY POLICY
(Health Insurance Portability and Accountability Act)

I have read the North Valley Family Dentistry HIPPA Privacy Policy and understand my rights to privacy.

_____ _____

Signature Date

_____ _____

Signature of Parent or Guardian Date

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 Citi Health Card. Our financial Coordinator would be happy to give you more information on this option.

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