"Quality Dentistry, Affordable Service, Compassionate Care."

WELCOME

Thank you for selecting us for your dental care. To ensure we select the best care for you, please complete this form. If you have any questions, please let us know.

Patient Information

Patient Name ______________________ Date of Birth ______________ SSN ____________
Patient Address ______________________ City, State, Zip ______________________
Home Phone (____________ Work Phone ( ) ______________ Cell ( ) ______________
At which number(s) are we able to leave messages? ☐ Home ☐ Work ☐ Cell
Marital Status ______________ Email Address ______________________
Employer ______________________ Occupation ______________________
Spouse/Parent/Guardian Name ______________________
How did you hear about our office? Whom may we thank for your referral? ______________________

Authorization to Disclose

I authorize the disclosure of all medical information to the following person(s):

Name ______________________ Number) ____________ Relationship ______________
Name ______________________ Number ( ) ____________ Relationship ______________
EMERGENCY CONTACT: Name ______________________ Number ______________________

Dental Insurance Information

Subscriber Name ______________________ Relationship ______________________
SS# or ID# ______________________ Date of birth ______________________
Insured's Employer ______________________ Occupation ______________________
Employer Address ______________________
Insurance Company ______________________ Group Number ______________________

Additional Dental Insurance Coverage

Subscriber Name ______________________ Relationship ______________________
SS# or ID# ______________________ Date of birth
Insured's Employer ______________________ Occupation ______________________
Employer Address ______________________
Insurance Company ______________________ Group Number ______________________

Authorization and Release

I certify that the above information is correct to the best of my knowledge. To the extent permitted by law, I consent to the use and disclosure of my protected health information to third party payers or health practitioners. I understand that the ESTIMATED co-pays, non- covered procedures and/or deductibles are DUE AT THE TIME OF SERVICE. I agree to be responsible for all remaining charges for dental services that are not paid by my dental benefit plan. This applies regardless of whether the estimated treatment included an expected insurance benefit, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to this office.

Patient/Guardian Signature ______________________ Date: ____/____/____
Dentist's Signature ______________________ Date: ____________

Please Complete Other Side

Completed by Employee Only Initial _______ Date: ______________

Patient Name________________________ **Date of Birth**___/____/_____

Dental History

Are you aware of any dental problems at this time?

____

When was your last dental visit? ______________ What was done? ___________________________

Previous Dentist's Name ______________________ Address _____________________________

Is there a reason you left your previous dentist? ____

Are you experiencing or have you experienced any of the following?

☐ Hot/Cold Sensitivity ☐ Frequent cavities

☐ Unpleasant Breath ☐ Buildup of plaque/calculus/tartar

☐ Bleeding Gums ☐ Gum treatments or Periodontal Surgery

☐ Tender Gums ☐ Orthodontic Treatment

☐ Food gets caught ☐ Oral Surgery

☐ Clench or grind your teeth ☐ Endodontic Treatment *(root canal)*

How often do you brush? ____________ Manual or Electric (circle one) How often do you floss? ___________

Have you ever been told to take antibiotics prior to dental appointments? Y / N Reason? _________________

Do you usually have dental anesthetic (teeth numbed) for dental work? Y / N

Have you had any problems or complications with previous dental treatment? Y / N

Have you ever whitened your teeth? Y / N

Are you planning to keep your remaining teeth your whole lifetime? Y / N

If you could change anything about your teeth or smile, what would that be? __________________________

Allergies

☐ Aspirin ☐ Codeine ☐ Erythromycin ☐ Hay Fever

☐ Latex ☐ Penicillin ☐ Sulfa ☐ Other________________

Medical History

Physician's Name & Phone Number ____

Date of last physical____/____/______ Currently under a phycian's care? Y / N If yes, why_________________

Do you have or have you had any of the following conditions:

☐ Anemia ☐ Arthritis ☐ Artificial Joints ☐ Asthma

☐ Blood Disease ☐ Cancer ☐ Diabetes ☐ Dizzy Spells or Fainting

☐ Epilepsy or Seizures ☐ Excessive Bleeding ☐ Glaucoma ☐ Head Injury

☐ Heart Condition ☐ Heart Disease ☐ Heart Murmur ☐ Heart Pacemaker

☐ Hemophilia ☐ Hepatitis A (Infectious) ☐ Hepatitis B (Serum) ☐ Hepatitis C or Other

☐ Herpes ☐ High Blood Pressure ☐ HIV + / AIDS ☐ Jaundice

☐ Kidney Disease/Trouble ☐ Liver Disease ☐ Low Blood Pressure ☐ Mental Disorder

☐ Nervous Disorder ☐ Osteoporosis ☐ Pregnant or Nursing ☐ Radiation Therapy

☐ Respiratory Problems ☐ Rheumatic Fever ☐ Rheumatism ☐ Sexually Trans. Disease

☐ Sinus Trouble ☐ Stomach Problems ☐ Stroke ☐ Tuberculosis (TB)

☐ Tumors ☐ Ulcers ☐ Other_______________

Have you ever had a disease, condition, serious illness or major surgery not listed above? Yes/ No

If yes, explain: ____

Have you ever taken Fosamax, Boniva, Actonel or other bisphosphonates? Y / N If yes, what: _____________

Have you used tobacco products in the last 7 years? Y / N If yes, what_______________________________

Do you consume alcoholic beverages or use recreational drugs? Y / N If yes, what: _____________________

If female, are you pregnant? Y / N If yes, # of weeks _______ Nursing? Y / N

Using Birth Control Medications? Y / N

Please list all medications you are currently taking, *include prescription and non-prescription:*

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

I certify that the above information is complete and accurate.

Patient/Guardian Signature____ Date:____/____/______

Dentist's Signature____ Date:____/____/______

NOTICE OF PRIVACY PRACTICES ACKNOWLEDEMENT AND PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and dental certifications.

Unless requested otherwise, we may use or disclose protected health information to a family member, friend, personal representative, or other individual to the extent necessary to coordinate health care or payment for health care.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ____

Relationship to Patient: ____

Signature: ____

Date: ____/____/________

OFFICE USE ONLY

I attempted to obtain the patient's acknowledgement on the Notice of Privacy Practice, Acknowledgement and Consent, but was unable to do so as documented below.

____

____

____

8573 Urbandale Ave. Urbandale, Iowa 50322
Phone: (515) 279- 3848 Fax: (515) 279-4479
www.davidsonfamilydentistry.com

CANCELLATION POLICY

Every patient at Davidson Family Dentistry is individually scheduled with the dentist or hygienist. We do not overbook our patients. Emergencies, conflicts, and illnesses do occasionally require that we reschedule our patients. We understand that emergencies, conflicts, and illnesses occur in the lives of our patients as well. When these occur, we require at least a 24 hour prior notice for cancellation.

To assist you, we will attempt to contact you at least 24 hours prior to your appointment by phone at the phone number(s) you provided to us. Any appointment cancelled prior to 24 hours to the scheduled appointment will not be recorded. Any appointment cancelled within 24 hours of the scheduled appointment time will be recorded in you patient record as a cancelled appointment. Any appointment not attended and not cancelled will be recorded as a failed appointment. Patients will be charged $50 for any recorded failed or late cancelled appointment. Every patient will be allowed two recorded failed or late cancelled appointment within a two year period prior to charges being assessed. We reserve the right to dismiss any patient from our practice on any grounds including cancelled or failed appointments.

We continue to strive to be an office that is very respectful of our patients' time and money. Our staff to patient ratio is 3:1. This cancellation policy is designed to help us continue to offer quality dental care and customer service to all of our patients.

Please acknowledge receipt of this information by signing and dating this form. A copy will be given to you if requested and the original will be stored with your permanent records.

DAVIDSON FAMILY DENTISTRY

I acknowledge I have read and approved the above cancellation policy for myself and any minor children as of this date ____/____/________.

____

Signature

____

Print Name

ADA Center for Professional Success™

Iowa

We will take reasonable steps to provide free-of-charge language assistance services to people who speak languages we are likely to hear in our practice and who don't speak English well enough to talk to us about the dental care we are providing.

Spanish:
Tomaremos acciones razonables para proporcionar servicios de asistencia lingüística gratuitos a aquellas personas cuyo lenguaje escuchemos frecuentemente en nuestro consultorio y que no hablen un inglés lo suficientemente bueno como para hablar con nosotros sobre el servicio odontológico que suministramos.

Chinese:
我们将有序地做到提供免费的语言服务使我们能听懂英语不好的人向我们咨询有关牙齿护理

Vietnamese:
Chúng tôi sẽ thực hiện các bước cần thiết để cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho những người giao tiếp bằng những ngôn ngữ mà chúng tôi có thể nghe thấy tại phòng khám của mình và cho những người không có đủ trình độ tiếng Anh để thảo luận về dịch vụ chăm sóc nha khoa mà chúng tôi đang cung cấp.

Serbo-Croatian:
Предузећемо разумне кораке да обезбедимо бесплатну преводилачку помоћ за особе које говоре језике са којима се током рада чешће сусрећемо, а који не говоре енглески довољно добро да би могли да разговарају са нама о стоматолошкој услузи коју пружамо.

German:
Wir werden angemessene Schritte unternehmen, um denen eine gebührenfreie Sprachunterstützung zu bieten, die Sprachen sprechen, die wir möglicherweise in unserer Praxis hören, die aber kein Englisch sprechen, das gut genug ist, um mit uns über die Zahnpflege zu sprechen, die wir anbieten.

Arabic:
سوف نقوم باتخاذ خطوات معقولة من أجل توفير خدمات المساعدة اللغوية بدون تكلفة للأشخاص الذين يتحدثون لغات أخرى من المرجح أن نستمع إليها خلال ممارستنا والذين لا يتقنون تحدث الإنجليزية بشكل جيد يمكنهم من التحدث إلينا فيما يتعلق برعاية الأسنان التي نقدمها.

Laotian:
ພວກເຮົາຈະໃຊ້ຂັ້ນຕອນທີ່ເໝາະສົມ
ເພື່ອໃຫ້ບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາບໍ່ເສຍຄ່າແກ່ຄົນຜູ້ທີ່ເວົ້າພາສາທີ່ພວກເຮົາອາດຈະໄດ້ຍິນຢູ່ໃນການຝຶກຊ້ອມຂອງພວກເຮົາ ແລະ ຜູ້ທີ່ບໍ່ເວົ້າພາສາອັງກິດໄດ້ດີພໍ ເພື່ອລົມກັບພວກເຮົາກ່ຽວກັບການເບິ່ງແຍງດູແລແຂ້ວທີ່ພວກເຮົາກໍາລັງຈັດໃຫ້.

Korean:
저희는 적절한 조치를 통하여 언어 지원 서비스를 무료로 제공할 것입니다. 다만, 실제로 저희에게 관심이 있는 언어를 쓰지만 저희 치아 관리 서비스에 대해 의견을 줄 수 있을 만큼 영어로 의사소통이 원활하지 않는 경우로 한정합니다

Hindi:
हम उन व्यक्तियों को, जो कि ऐसी भाषाएं बोलते हैं जो हम अपने अभ्यास में संभावित रूप में सुनना चाहते हैं और जो हमारे द्वारा प्रदान की जाने वाली डैंटल देखभाल के बारे में हमारे साथ उचित ढंग से अंग्रेज़ी नहीं बोलते, मुफ़्त सेवाएं प्रदान करने के लिये उचित कदम उठायेंगे।

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French:
Nous prendrons les mesures raisonnables pour fournir des services d'assistance linguistique gratuits pour les individus qui parlent des langues que nous sommes susceptibles d'entendre durant nos séances et qui ne parlent pas suffisamment bien l'anglais pour discuter avec nous concernant les soins dentaires que nous fournissons.

Pennsylvanian Dutch:
Mir zelle unser Beschtes browiere fer Hilf griege fer ennich ebber as Druwwel hett fer verschtehe was mer an schwetze is in Englisch weeich Zaahdokteres do. Die Hilf, as mer aabiede kennt, deet nix koschte.

Thai:
เราได้ก้าวไปอีกขั้นด้วยการให้บริการผู้ช่วยด้านภาษาโดยไม่มีค่าบริการ
ให้กับผู้ที่ไม่สามารถสื่อสารด้วยภาษาอังกฤษเกี่ยวกับการดูแลทันตกรรมที่เราให้บริการได้ดีพอและใช้ภาษ
าที่เรามักจะได้ยินบ่อยในศูนย์ทันตกรรมของเรา

Tagalog:
Gagawin namin ang mga makatwirang hakbang para maibigay namin ng walang bayad ang mga tulong na serbisyo sa wika para sa mga taong nagsasalita ng mga wikang karaniwan naming naririnig sa aming pagsasagawa at sa mga hindi bihasa sa pagsasalita ng Ingles na sasangguni sa amin tungkol sa pangangalaga ng ngipin na ibinibigay namin.

Karen:
ပကဟံးန့ၢ်တၢ်အပတီၢ်လၢအကြၢးဝဲဘၣ်ဝဲတဖၣ် လၢကဟ့ၣ်လီၤ ကျိာ်တၢ်
တိစၢၤမၤစၢၤတၢ်မၤစၢၤလၢအကလီ ဆူပှၤလၢအကတိၤကျိာ်လၢပအဲၣ်ဒိးန့ၢ်
ဟူလၢပတၢ်ဖံးတၢ်မၤအပူၤ ဒီးပှၤလၢကတိၤအဲကလံးကျိာ်တဘၣ်ဂ့ၤဂ့ၤလၢ
ကတဲသကိးတၢ်ဘၣ်ဃးဒီးမဲတၢ်ကွၢ်ထွဲလၢပဟ့ၣ်လီၤအီၤတဖၣ်န့ၣ်လီၤ.

Russian:
Мы принимаем необходимые меры, чтобы предоставить бесплатные услуги переводчика для общения на языках, с которыми мы сталкиваемся в нашей практике с клиентами, которые не владеют английским язы ком достаточно, чтобы обсудить с нами стоматологическое обслуживание, которое мы предоставляем.

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