



"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, Marital Status, Email Address, Employer, Occupation, Spouse/Parent/Guardian Name, How did you hear about our office?

Authorization to Disclose

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

Name, Number, Relationship (two entries)

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?

- | | |
|---|---|
| <input type="checkbox"/> Hot/Cold Sensitivity | <input type="checkbox"/> Frequent cavities |
| <input type="checkbox"/> Unpleasant Breath | <input type="checkbox"/> Buildup of plaque/calculus/tartar |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Gum treatments or Periodontal Surgery |
| <input type="checkbox"/> Tender Gums | <input type="checkbox"/> Orthodontic Treatment |
| <input type="checkbox"/> Food gets caught | <input type="checkbox"/> Oral Surgery |
| <input type="checkbox"/> Clench or grind your teeth | <input type="checkbox"/> Endodontic Treatment (<i>root canal</i>) |

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

- | | | | |
|----------------------------------|-------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Other _____ |

Medical History

Physician's Name & Phone Number _____

Date of last physical ____ / ____ / ____ Currently under a physician's care? Y / N If yes, why _____

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

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dizzy Spells or Fainting |
| <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Head Injury |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Heart Pacemaker |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Hepatitis A (Infectious) | <input type="checkbox"/> Hepatitis B (Serum) | <input type="checkbox"/> Hepatitis C or Other |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV + / AIDS | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Kidney Disease/Trouble | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Pregnant or Nursing | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Sexually Trans. Disease |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Tumors | <input type="checkbox"/> Ulcers | <input type="checkbox"/> 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 ACKNOWLEDGEMENT 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.



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 your 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 appointments 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



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 escuchamos 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 نستمتع إليها خلال ممارستنا والذين لا يتقنون تحدث الإنجليزية بشكل جيد يمكنهم من التحدث إلينا فيما يتعلق برعاية الأسنان التي نقدمها.

Laotian:

ພວກເຮົາຈະໃຊ້ຂັ້ນຕອນທີ່ເໝາະສົມ ເພື່ອໃຫ້ບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາບໍ່ເສຍຄ່າແກ້ຄົນຜູ້ທີ່ເວົ້າພາສາທີ່ພວກເຮົາອາດຈະໄດ້ຍິນຢູ່ໃນການຝຶກຊ້ອມຂອງພວກເຮົາ ແລະ ຜູ້ທີ່ບໍ່ເວົ້າພາສາອັງກິດໄດ້ດີພໍ ເພື່ອລົມກັບພວກເຮົາກ່ຽວກັບການເບິ່ງແຍງດູແລະຂັ້ນຕອນທີ່ພວກເຮົາກຳລັງຈັດໃຫ້.

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 डेंटल देखभाल के बारे में हमारे साथ उचित ढंग से अंग्रेज़ी नहीं बोलते, मुफ्त सेवाएं प्रदान करने के लिये उचित कदम उठाएंगे।



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:

เราได้ก้าวไปอีกระดับด้วยการให้บริการผู้ช่วยด้านภาษาโดยไม่มีค่าบริการให้กับผู้ที่ไม่สามารถสื่อสารด้วยภาษาอังกฤษเกี่ยวกับการดูแลทันตกรรมที่เราให้บริการได้ดีพอและใช้ภาษาที่เรามักจะได้ยินบ่อยในศูนย์ทันตกรรมของเรา

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 sasangunin sa amin tungkol sa pangangalaga ng ngipin na ibinibigay namin.

Karen:

ပကဟံးန့ၢ်တၢ်အပတီၢ်လၢအကြးဝဲဘၣ်ဝဲတဖၣ် လၢကဟ့ၣ်လီၤ ကျိၣ်တၢ်
တိၣ်စၢၤမၤတၢ်မၤတၢ်လၢအကလီၤ ဆူပုၤလၢအကတိၤကျိၣ်လၢပအဲၣ်ဒီးန့ၢ်
ဟူလၢပတၢ်ဖံးတၢ်မၤအပူၤ ဒီးပုၤလၢကတိၤအဲၣ်ကလံးကျိၣ်တဘၣ်ဂ့ၤဂ့ၤလၢ
ကတဲသကိးတၢ်ဘၣ်ဃးဒီးမဲတၢ်ကွၢ်ထွဲလၢပဟ့ၣ်လီၤအီၤတဖၣ်န့ၢ်လီၤ.

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 языком достаточно, чтобы обсудить с нами стоматологическое обслуживание, которое мы предоставляем.