Name ____________________________ Phone Number ____________________

DOB ______________________ Social Security # ___________________________

Mailing Address ____

City _______________________ State _________________ ZIP ___________

Email ____

Emergency Contact Name ____

Phone # ______________________ Relationship __________________________

~ Medical History ~

Patient Name: ______________________

□ Check if there are **NO CHANGES**.

Preferred Pharmacy -

Pharmacy Name: ______________________

Address or Cross Streets: ______________________

□ Check if you require a **pre-medication** prior to your appointments.

List Reason: ______________________

□ Check if you are currently taking any blood thinners.

Please check any of the following that apply to you:

- □ Allergies (Medications/Seasonal)
  Please Specify: __________
- □ Anemia
- □ Anxiety
- □ Artificial Heart Valve
- □ Artificial Joints
- □ Asthma
- □ Blood Disease
  Please Specify: __________
- □ Cancer
- □ Chemotherapy
- □ Diabetes
- □ Depression
- □ Dizziness / Fainting
- □ Drug Addiction
- □ Emphysema
- □ Excessive Bleeding
- □ Glaucoma
- □ Heart Conditions
  Please Specify: __________
- □ Heart Murmur
- □ Hepatitis A / B / C (Please circle)
- □ High Blood Pressure
- □ HIV / AIDS
- □ Kidney Disease
- □ Liver Disease
- □ Mitral Valve Prolapse
- □ Osteoporosis
- □ Pacemaker
- □ Radiation (Head / Neck)
- □ Respiratory Problems
  Please Specify: __________
- □ Rhematic Fever
- □ Scarlet Fever
- □ Seizures
- □ Stomach Problems
  Please Specify: __________
- □ Stroke
- □ Thyroid Disease
- □ Tuberculosis
- □ Ulcers
- □ OTHER *(Please list)*:
  ____
  ____
  ____

FOR WOMEN ONLY:

- □ Birth Control
- □ Breast Feeding
- □ Pregnant

What medications are you currently taking?

____
____
____
____
____

For what conditions?

____
____
____
____
____

Are you under a physician's care? □ YES □ NO

Physician Name: ______________________

Phone Number: ______________________

□ ***Please check if you are taking Bisphosphonate because you would be at high risk for Osteonecrosis.***

Do you have an allergy to any of the following?

- □ Aspirin
- □ Codeine
- □ Erythromycin
- □ Latex
- □ Local Anesthesia
- □ Nitrous Oxide
- □ Penicillin
- □ Other: __________

Patient or Guardian Signature: ______________________ ***Date:*** __________

Dentist Signature: ***Date:***

~ Dental History ~

Please check any of the following that apply to you:

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, earaches, neck pain
- ☐ Mouth ulcers or Cold sores
- ☐ Jaw Joint pain
- ☐ Broken tooth or fillings
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen, or irritated gums
- ☐ Loose, tipped, or shifted teeth
- ☐ Bad breath or bad taste in your mouth
- ☐ Snoring or Sleep Apnea

Do you have or have you had any of the following?

- ☐ Dentures
- ☐ Partial Dentures
- ☐ Braces
- ☐ Gum Treatments

Please share the following dates:

Your last cleaning: _____ / _____

Your last oral cancer screening: _____ / _____

Your last complete x-rays: _____ / _____

Name of previous Dentist:

____

City: ____________________ State: __________

Phone Number: ______________________________

Why did you leave your previous dentist?

____

What is the most important thing to you about your future smile and dental health?

____

If you could whiten your teeth for a cost anyone could afford, would you? ____________________

Do you smoke or use chewing tobacco? How much? For how long?

____

If you could change your smile, you would:

- ☐ Have whiter teeth
- ☐ Have straighter teeth
- ☐ Close spaces
- ☐ Replace metal fillings w/ tooth-colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ *Have a Complete 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 current dental health?

1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your dental visit today?

____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), 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 that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand 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 this organization at any time 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 healthcare operations. I also understand 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: ____________________

Patient Signature or Guardian: ____________________ **Date:**__________

Relationship to patient: ____________________

Appointment Cancellation and Late Policy

Here at High Desert Dental we strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows: We require that you give our office **48-hour** notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of **$50.00** will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility.

No future appointments can be scheduled nor can records be transferred without the payment of this fee. Additionally, if a patient is more than **15 minutes** late without prior notice for a scheduled appointment, we will consider this a missed appointment and the **$50.00** cancellation fee will be charged. If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have. We thank you for your patronage.

I have read and understand the Appointment Cancellation/Late policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I,________________________, have received a copy of High Desert Dental's

cancellation/late policy.

Signature: ____________________________ **Date:** ____________________