

Welcome To Our Office!

Thank you for selecting our dental HealthCare team! We strive to provide you with the best possible dental care. To help us provide personalized and comfortable dentistry, please fill out this form completely in ink. If you have any questions or need assistance, please ask and we will be glad to help.

1. Personal Patient Information

Today's Date _____

Name _____

Pref. Name _____

Address _____

City, State, Zip _____

Male Female Minor Single Married Divorced Widowed Separated

Birth Date _____

Social Security # _____

Employer _____

Occupation _____

Drivers License # _____

How did you find out about us? _____

2. Responsible Party

Name _____

Relationship to Patient _____

Birth Date _____

Drivers License # _____

Social Security # _____

Address _____

City, State, Zip _____

Employer _____ Occupation _____

Employer Address _____ City, State, Zip _____

Dental Insurance Company _____ Insurance ID # _____

Insurance Address _____ Insurance Phone# _____

3. Telephone

Home _____ Work _____ Cellular _____

E-Mail _____

Where do you prefer to receive calls? _____

When is the best time to reach you? _____

Would you like to be included in our "short call" list to be available for an appointment within a few hours? YES NO (please circle)

In the event of an emergency, who should we contact?

Name _____ Relationship _____ Phone _____

Health History

▼ Dental History

Name _____ Birth Date _____ Today's Date _____

1. What is the reason for your visit today? _____
2. If your visit is an emergency how long have you had symptoms? _____
3. When was your last dental visit? _____ What was your visit for? _____
4. How often do you brush your teeth? _____
5. How often do you floss? _____
6. What are your goals for your dental health? _____
7. What texture of tooth brush do you use? ___ SOFT ___ MEDIUM ___ HARD

8. Do your gums bleed while brushing?	Y N	16. Have you had any head, neck or jaw injuries?	Y N
9. Do your gums bleed while flossing?	Y N	17. Do you have frequent headaches?	Y N
10. Do you have pain in any of your teeth while you're brushing?	Y N	18. Do you clench or grind your teeth while you are awake or at night?	Y N
11. Have you noticed any loosening of your teeth?	Y N	19. Have you ever had:	
12. Are your teeth sensitive to hot, cold, sweet food or liquids?	Y N	a. Orthodontic treatment (braces)?	Y N
13. Does your food tend to get caught between your teeth?	Y N	b. Oral Surgery?	Y N
14. Do you have any sores or lumps in or near your mouth?	Y N	c. Gum treatment?	Y N
15. Have you experienced any of the following problems?		d. Your teeth ground down or bite adjusted?	Y N
a. Clicking?	Y N	e. Wore a bite plane or night guard?	Y N
b. Pain (joint, ear, side of face)?	Y N	20. Are you satisfied with the appearance of your teeth?	Y N
c. Difficulty in opening or closing?	Y N	21. Have you ever worn a mouth guard during athletic activities?	Y N
d. Difficulty in chewing?	Y N	22. Is there anything about having dental treatment that bothers you?	Y N
		23. Have you ever bleached or whitened your teeth?	Y N
		24. Do you have dental implants?	Y N

▼ Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

1. Are you currently under a physician's care? ----- Y N
(If yes please list what you're being treated for) _____
2. Have you ever had Rheumatic fever, Rheumatic heart disease, or a heart murmur?----- Y N
(Please circle if you have any of the above) If yes when was it diagnosed? _____
3. Have you ever taken the weight loss medication Phen-Phen?----- Y N
(If yes, when and for how long?) _____
4. Have you ever had your heart valves checked after taking Phen-Phen?----- Y N
(If yes, was there any damage to your heart valves?) _____
5. Have you ever had a tumor or cancer? ----- Y N
(If yes please list what type of cancer, when it was diagnosed, where it was located and how it was treated)

6. Have you ever received chemotherapy, x-ray, radium, or cobalt treatments? ----- Y N
(If yes when, and what for?) _____

Health History Continued (page 2)

7. Are you currently taking or previously taken any bisphosphonates?
(Fosamax, Actonel, Boniva, Zometa, Skelid, Didronel, Aredia, Reclast) ----- Y N
(If yes, how long have you been taking the medication and for what?) _____
8. Do you have Cataracts or Glaucoma? ----- Y N
(If yes, please circle those that apply to you.) _____
9. Have you had eye surgery in the past year? ----- Y N
10. Do you have high or low blood pressure? ----- Y N
(If yes, please circle the one that may apply to you.) _____
11. Have you ever had a heart attack? ----- Y N
(If yes, please provide dates.) _____
12. Do you have a pacemaker? ----- Y N
(If yes when was it placed?) _____
13. Does mild exercise leave you short of breath? ----- Y N
14. Have you ever had a liver condition such as jaundice, hepatitis, or cirrhosis? ----- Y N
(If yes, please circle those that may apply to you.) _____
15. Have you suffered from chest pains or angina? ----- Y N
(If yes, please circle those that apply to you.) _____
16. Have you ever had kidney or bladder trouble? ----- Y N
(If yes, please circle those that apply to you.) _____
17. Have you ever had syphilis, gonorrhea or any other sexually transmitted disease? ----- Y N
18. Do you have diabetes? ----- Y N
(If yes, are you controlled by Insulin, pills, diet, or nothing – Please circle those that apply.) _____
19. Do you consider yourself a nervous or tense person? ----- Y N
20. Have you ever taken any medication for nervousness or depression? ----- Y N
(If yes please list them.) _____
21. Do you have a tendency to bleed longer than normal from small cuts? ----- Y N
22. Have you ever had seizures, convulsions or fainting spells? ----- Y N
(If yes, circle those that may apply to you.) _____
23. Do you bruise easily? ----- Y N
24. Do you have any blood disorders, such as leukemia or anemia? ----- Y N
25. Have you ever had a blood transfusion? ----- Y N
(If yes, in what year?) _____
26. Have you ever been diagnosed with Hepatitis? ----- Y N
(If yes, please circle those that apply.) A, B, C, D, or E
27. Do you have ringing in your ears or loss of hearing? ----- Y N
(If yes, circle those that apply to you.) _____
28. Have you had any chest x-rays in the past 24 months? ----- Y N
29. Have you ever been diagnosed with Tuberculosis? ----- Y N
(If yes, please provide the year.) _____
30. Have you ever been diagnosed with Rheumatoid Arthritis or any other form of Arthritis? ----- Y N
31. Have you ever been diagnosed with Hyperthyroidism or Hypothyroidism? ----- Y N
(If yes, please circle which one.) _____
32. Have you ever been diagnosed with Emphysema or Chronic Obstructive Pulmonary Disease? ----- Y N
(If yes, circle which one.) _____
33. Have you ever been diagnosed with HIV or AIDS? ----- Y N
34. Have you ever had a joint replacement? ----- Y N
(If yes, please provide the location and date.) _____
35. Do you require extra pillows to sleep at night? ----- Y N
36. Do your ankles swell? ----- Y N
37. Do you have frequent sore throat or neck pains? ----- Y N
38. Have you ever had a stroke? ----- Y N
(If yes, please provide dates.) _____
39. Do you ever have skin rashes or severe itching? ----- Y N
(If yes, what causes it?) _____
40. Do you drink grapefruit juice on a consistent daily basis? ----- Y N
41. Do you have asthma or Hay Fever? ----- Y N
(If yes, do you use an inhaler?) _____
42. Do you have osteoporosis? ----- Y N

Health History Continued (page 3)

For Women:

- 42. Are you pregnant? ----- Y N
(If yes, when are you due?) _____
- 43. Are you currently nursing? ----- Y N
- 44. Are you taking birth control pills? ----- Y N

▼ HOSPITALIZATIONS

- 1. Have you ever been hospitalized? ----- Y N
(If yes, when and what for?) _____

▼ MEDICATIONS

- 1. Presently, are you taking any medications? This includes over the counter, herbs, vitamins or prescription. ----- Y N
(If yes, please list all medications and milligrams of the same.) _____
- 2. Are you currently taking Tagamet (Cimetidine)? If so how often? ----- Y N
- 3. Are you currently taking St. Johns Wart? ----- Y N
If so how often? _____

▼ ALLERGIES

- 1. Are you allergic to or have you reacted to any of the following medications:
 - a. Local Anesthetics ----- Y N
 - b. Penicillin or Amoxicillin ----- Y N
 - c. Sulfa Drugs ----- Y N
 - d. Barbiturates, sedatives, or sleeping pills ----- Y N
 - e. Aspirin ----- Y N
 - f. Codeine or other narcotics ----- Y N
 - g. Other (please list) _____ Y N

▼ SOCIAL HISTORY

- 1. Do you smoke? ----- Y N
(If yes, please provide the approximate number of packs per day. _____ How many years? _____)
- 2. Do you chew tobacco? ----- Y N
(If yes for how long?) _____
- 3. Do you drink alcoholic beverages? ----- Y N
(If yes, approximately how many drinks per week?) _____

▼ FAMILY HISTORY

- 1. Does any one in your family have a history of diabetes? ----- Y N
(If yes, whom?) _____
- 2. Does any one in your family have a history of heart disease? ----- Y N
(If yes, whom?) _____

If Dr. Larson or any of his staff should injure themselves during treatment, I hereby consent for H.I.V. (AIDS), Hepatitis B or C testing for myself, spouse, or children at no expense to me.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) personal health. It is my responsibility to inform the dental office of any changes in my medical status. Further, by signing below I authorize Dr. Larson and staff to render treatment and if applicable, provide my insurance company with required information to process my dental claim.

Signature of Patient or Legal Guardian

Date

Please Handle Me with Care

Please circle the number next to the statement that concerns you or describes your situation:

1. I gag easily.
2. I feel out of control when I'm lying down in the dental chair.
3. I have not been to the dentist for a long time, and I feel uncomfortable about what you will say about my teeth and my dental hygiene.
4. Pain relief is a top priority for me.
5. I don't like shots (or I've had a bad reaction to shots).
6. Please tell me what I need to know about my mouth so I am better able to make an informed decision.
7. My teeth are very sensitive.
8. I don't like the sound of that tool that makes the picking and scraping noise. It's like someone is scratching fingernails on a blackboard.
9. I don't like cotton in my mouth.
10. I hate the noise of the drill.
11. Please respect my time. I don't want to sit in the reception area for an extended period of time.
12. I want to know the cost upfront. No money surprises please.
13. I have difficulty listening and remembering what I hear while sitting in the dental chair.
14. I have health problems and questions that we need to discuss.

The Handle Me with Care Partnership Pact:

I ask that you honestly inform me of all my dental problems. I want you to make me aware of the best quality dentistry available today. Then we can discuss how I can make healthy choices that will work within my budget. I also want to know all the pain relief options available to me in your dental office, how each dental procedure will work, and how much of my time will be required.

Patient Signature

Date

General Release of Information/ Assignment of Benefits

I authorize the release of any information to my insurance company that may be required to process my claim. _____ Initial

I authorize the release of any medical information to consulting or referring physicians. _____ Initial

I authorize the direct payment of insurance benefits to Dr. Larson for services rendered to myself or my Dependents. _____ Initial

I authorize treatment by Dr. Larson and staff. _____ Initial

I consent to taking dental photographs to document my dental progress. _____ Initial



Financial Responsibility Agreement

Our fees are meant to be reasonable and competitive, we will be happy to discuss them with you. Please don't hesitate to ask about the cost of a service before it is performed.

Our collection policy is a necessary part of assuring the financial resources needed to maintain quality medical services for our patients. In order to establish optimal relations with our patients and avoid potential misunderstanding and confusion regarding our payment policies, our staff is available to inform you of the financial payment policies of the office.

We require payment at the time of service if insurance does not cover any portion of your visit, or if your deductible has not been met. All co payments are required at the time of service.

If you are visiting us for the first time on an emergency basis, we require your payment in full at the time of the appointment. If your payment results in overpayment because of subsequent insurance payment, it will be refunded to you promptly.

INSURANCE: We will, as a courtesy to you, bill your insurance if you provide us with current information. This is done with the understanding that you remain totally responsible for your charges regardless of your insurance coverage. Because we file your insurance claim for you does not mean that we accept your company's payment as "payment in full" unless we have a contract with your company. Even though you may have an insurance claim pending, you will receive a statement for the outstanding balance on your account. We cannot claim responsibility for collecting insurance claims 60 days after the date of service, or for negotiating a disputed claim. However, we will do all we can to help you secure your payment. We will look to you for full payment if your insurance has not been paid within 60 days of service. WE DO NOT HAVE ANY CONTROL OVER YOUR INSURANCE COMPANY'S INTERPRETATION OF THEIR RESPONSIBILITY TO PAY YOUR BILL. OUR AGREEMENT IS WITH YOU, THE PATIENT.

ACKNOWLEDGEMENT OF OUR INSURANCE POLICY ----- _____ Initial

I personally guarantee and accept responsibility for all medical charges incurred by myself or my dependents regardless of any insurance coverage I may or may not have. This includes but is not limited to:

- expired insurance or loss of eligibility
- work related injury (we must have prior authorization to bill your employer)
- cosmetic services
- services deemed not "medically necessary" or "not covered" by my insurance company
- any balance that my insurance has not paid in 60 days. ----- _____ Initial

** If your account is turned over to our collection company and you decide to return to our office, all account balances must be paid in full and you will be responsible for any charges assessed by the collection agency. **

The appointment times we reserve are exclusively for you. Appointments missed or canceled without 48 hours notice will be charged \$55. Accounts over 30 days old are subject to a monthly finance charge. There is also a \$30 charge for all returned checks.

Signature _____ Date _____
(This signature indicates that I have read, understand, and authorized all the above items)

I acknowledge that I received a copy of Dr. Judd Larson's Notice of Privacy Practices.

Patient name _____

Signature _____ **Date** _____