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**Are you allergic to any of the following?** *(Circle all that apply)*

☐ Aspirin ☐ Acrylic ☐ Metals ☐ Codeine ☐ Jewelry ☐ Penicillin ☐ Dental Anesthetics ☐ Sulfa Drugs ☐ Latex

Other: _____

**Have you ever had any of the following diseases or medical problems?** (Circle all that apply)

| | | | |
|---|---|---|---|
| ☐ Abnormal Bleeding | ☐ Congenital Heart Disorder | ☐ Heart Surgery/Pacemaker | ☐ Radiation Treatment |
| ☐ Alcohol/Drug Abuse | ☐ Diabetes | ☐ Hemophilia | ☐ Rheumatic Fever |
| ☐ Alzheimer's Disease | ☐ Difficulty Breathing | ☐ Hepatitis A/B/C | ☐ Shingles |
| ☐ Anemia | ☐ Easily Winded | ☐ High Blood Pressure | ☐ Sinus/Hay Fever |
| ☐ Arthritis | ☐ Emphysema | ☐ HIV/AIDS | ☐ Stroke |
| ☐ Artificial Joint/Valves | ☐ Epilepsy/Seizures | ☐ Hoarse/Chronic Cough | ☐ STI's |
| ☐ Asthma | ☐ Excessive Thirst | ☐ Kidney Problems | ☐ Sudden Weight Gain |
| ☐ Blood Disease | ☐ Fainting Spells | ☐ Liver Disease | ☐ Sudden Weight Loss |
| ☐ Blood Transfusion | ☐ Fatigue | ☐ Loss of Appetite | ☐ Swelling of Limbs |
| ☐ Bruise Easily | ☐ Frequent Headaches | ☐ Low Blood Pressure | ☐ Thyroid Problems |
| ☐ Cancer | ☐ Glaucoma | ☐ Lung Disease | ☐ Tuberculosis |
| ☐ Chemotherapy | ☐ Heart Attach/Chest Pain | ☐ Marijuana Use | ☐ Tumors/Growths |
| ☐ Colitis | ☐ Heart Disease | ☐ Mental Health/Psychiatric Care | Ulcers ☐ |
| ☐ Cold Sores/Fever Blisters | Heart Murmur ☐ | ☐ Mitral Valve Prolapse | |

Do you use controlled substance? ☐Y ☐N

Women: Are you currently pregnant? ☐Y ☐N Weeks:_____ Are you nursing? ☐Y ☐N

Oral Contraceptives: ☐Y ☐N

**I have answered all the above truthfully and to the best of my knowledge.**

_____ _____

Patient/Patient Representative Signature Date

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# Dental History

**Name:**

_____

**Please check any of the following problems that apply to you.**

- ☐ Sensitivity (hot, cold, sweet) - *Circle all that apply*
- ☐ Tooth Pain or discomfort when chewing
- ☐ Headaches, earaches, neck pain
- ☐ Jaw joint pain
- ☐ Teeth or fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifting teeth
- ☐ Bad breath or bad taste in your mouth

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

- ☐ *Dentures* _____ *placement*
- ☐ *Partial denture* _____ *placement*
- ☐ *Braces*
- ☐ *Periodontal (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: (_____) _____

**How often do you brush?**

_____

**How often do you floss?**

_____

**Do you regularly drink soda?** ☐Y ☐N

If yes, how much per week? _____

**Do you smoke or use tobacco/marijuana/vape?**

- ☐ Yes How Much_____ How Long_____
- ☐ No

**If you could change your smile, you would:**

- ☐ Make it brighter
- ☐ Make it straighter
- ☐ Close spaces
- ☐ Replace black metal fillings with tooth colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

**On a scale of 1-10 with 10 the highest rating:**

How important is your dental health to you?

**Where would you rate your current dental health?**

**Why did you leave your previous dentist?**

_____

_____

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

_____

_____

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# Ponderosa Family Dental Patient Care and Financial Policy

Welcome to Ponderosa Family Dental! We appreciate you choosing Dr. Curtis and our wonderful team to handle your oral healthcare needs. We strive to offer our patients the best experience possible at our office. In our efforts to serve you better, it is important that there be a mutual understanding between you (the patient) and our office (AFD). Please review the following guidelines and policies of our practice, and initial acknowledgment at each section as indicated.

## ***Insurance:*** *(If you do not have insurance, please continue to the next section)*

-- As a courtesy to our patients, we verify eligibility of coverage with your insurance company and obtain a general breakdown of your dental benefits. Any information obtained will be used to provide you an ESTIMATE of your cost for treatment. While we strive to provide accurate information, insurance companies do not provide AFD with specific details to the design of your plan, and any estimates provided by our office are not a guarantee of benefit payment. Ultimately, it is the patient's responsibility to understand the limitations of our insurance plan. _____ (patient initials)

-- Insurance payments are ordinarily received within 30-60 days from the time of filing a claim. If you insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time. If any payment is made by your insurance company directly to you for services billed by AFD, you recognize an obligation to promptly remit payment to AFD. _____ (patient initials)

## ***AFD Financial Guidelines:***

-- Fees for services, which include unpaid balances, deductibles and co-payments, are due at the time of service. Returned checks are subject to additional fees. _____ (patient initials)

-- Since we are a private dental practice, we are unable to accommodate payment plans. We accept payment via MasterCard, Visa, Cash, Check or Care Credit. _____ (patient initials)

-- I understand and agree that if I fail to make any of the payment to AFD for which I am responsible, my account may be assigned to a collection agency. I understand that if my account is assigned to a collection agency, AFD may add the amount for collection agency. I understand and agree that in the event legal action is commenced to collect on an outstanding balance, I will pay all costs associated with such action, including court costs and reasonable attorney fees. _____ (patient initials)

***Missed Appointment(s) and Cancellation Policy:*** Your appointment time is reserved specifically for you according to the treatment you have planned. We strive to maintain an on-time schedule for our patients and appreciate the same courtesy in return. If you are running late to your appointment, please contact our office to let us know. **AFD kindly asks 48-hour notice to alter your scheduled appointment, including cancelling or rescheduling.** We send appointment reminders through a text/email-based system and require confirmation that you will be coming to your schedule visit. If you prefer a phone call to confirm, please notify our Patient Care Coordinator when making the appointment. If you fail to confirm your appointment within the 48-hour window, you will be subject to a $75 cancellation fee, per hour that you are scheduled, and you will forfeit your appointment time to patients on our waiting list. _____ (patient initials)

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***X-rays and Exams:*** Our standard of care is to maintain on file a recent (within 36 months) series of full-mouth x-rays (FMX or Pano), on ALL our patients. In addition, Dr. Curtis will perform a Comprehensive Oral Evaluation on all new patients to our practice, or a patient that is re-establishing care; Periodic Oral Evalutations every 12 months for regularly attending patients; and Limited Oral Evaluations -- Problem Focused on patients requiring emergency care. If you have insurance, these services may fall under a different benefit tier that regular preventive procedures, and/or may be subject to your plan deductible. It is your responsibility to know the benefits your insurance plan allows for these services. **To all our patients** -- we appreciate your understanding that Dr. Curtis and his team cannot properly diagnose and/or treat your oral health without taking these x-rays and performing thorough examinations. _____ (patient initials)

***Patient Care Policy:*** We require our patients to sign treatment plans acknowleding that treatment options, including usual and customary fees, insurance estimates and estimated patient portions, are explained to you for all services rendered by Dr. Curtis and his team. We provide you a copy of this acknowledgement for your records and this form, including the signature, is documentation that you understand the cost associated with your recommended treatment. Signing this form does not obligate you to complete the treatment, however, if you choose to schedule the recommended, it serves as an agreement that you will honor your financial commitment to Dr. Curtis and his team for providing the services, as outlines in our financial guidelines. _____ (patient initials)

-- Adult patients are responsible for full payment at the time services are rendered. The adult accompanying a minor, and/or the parent or guardian of the minor are responsible for full payment.
_____ (patient initials)

-- Unaccompanied minors will be required to present a signed authorization form, which can be found on our website. Non-emergency treatment will be denied unless payment for services has been pre-authorized via Visa, Mastercard, Cash, Check or Care Credit at the time services are rendered. Children under the age of 14 may not be left unattended during appointments and we reserve the right to decline treatment to minors who do not have a signed authorization form in their possession. In addition, the responsible part on record will be charged a $75 cancellation fee should a minor arrive for an appointment without the proper representation or authorization.
_____ (patient initials)

## Personal Health Information (*PHI) Release Form

I_____ (please print your full name), on behalf of myself or my minor child, _____ (child/minor's name), do hereby authorize Ponderosa Family Dental to share the *Protected Health Information* (***PHI**) with the below listed entities. I understand that they will have full access to the account and treatment records, in addition to all personal information in files both digital and physical, unless I note otherwise on this form. I also agree they have the authority to make changes to the personal information and insurance information, as well as able to request copies of digital and/or physical records, unless otherwise noted.

Please print the full name and date of birth of those authorized to access your *PHI

Spouse:_____ DOB:_____

Parent:_____ DOB:_____

Other:_____ DOB:_____

Relationship:_____ DOB:_____

☐ I do not authorize release to anyone.

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***General Consent:*** I, the undersigned patient (parent/guardian of a patient who is a minor or unable to give legal consent, authorize Dr. Curtis and/or his hygienists where permitted by state aw, to perform an intra-oral examination of my teeth, as well as oral hard and soft tissues. I further consent to allow Dr. Curtis and/or his hygienists where permitted by state law, to perform an examination of the head and neck with the understanding that palpation (touching) of the head, face, and neck is necessary to adequately perform this examination. After receiving an explanation for the need for each, this consent also gives Dr. Curtis, as well as any of his associates, hygienists, or dental assistant where permitted by state law, consent to perform the following: Routin Radiographs (x-rays) or Imaging, General Teeth Cleaning, Periodontal (Gum Tissue) Probing, Application of Topical Flouride, Impressions for Study Casts, and/or Oral Cancer Screening.
_____ (patient initials)

By signing below, I authorize AFD to contact me via text, email or phone, as provided in my patient information profile for any lawful purpose. AFD is not responsible for any fees or charges I may incur from a phone, email or cellular carrier as a result of communciation. By signing below, I acknowledge that I have read AFD's policies and guidelines in their entirety and I agree to honor them as outlined.

Printed Name of Patient _____

Patient Signature _____ Date _____

Legal Guardian or Representative Signature _____

Relationship to Patient _____ Date _____

## Notice of HIPAA Privacy Practices

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a Federal program which requests that all medical records and other individually identifiable health information used or disclosed by us in any form are kept properly confidential. Ponderosa Family Dental (PFD) strives for complete HIPAA compliance and will always protect your personal information as if it is our own. The attached notice describes how medical information about you may be used by AFD and disclosed, and how you can get access to this information. Please read this section carefully. At any time, you may request a copy of this agreement.

I have reviewed all compliance information from AFD and understand AFD will comply with HIPAA guidelines.

Printed Name of Patient _____

Patient Signature _____ Date _____

Legal Guardian or Representative Signature _____

Relationship to Patient _____ Date _____

-- end of paperwork --