

How did you hear about our office?



Patient Information

Name: _____ ☐ M ☐ F Preferred Name: _____

DOB: _____ SS#: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone - Cell: _____ Work: _____ Home: _____

Text Message: ☐ Yes ☐ No

Responsible Party Name: _____ Address: _____

Responsible Party SS#: _____ Phone #: _____

Emergency Contact Name: _____ Ph#1: _____ Ph#2: _____

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Insurance Subscriber Information

(Please Give Drivers License or State Issued ID and Dental Insurance Card to Receptionist to Copy For File)

Subscriber Name: _____ DOB: _____ SS#: _____

Subscriber Address: _____

Employer: _____ Insurance Co: _____

ID#: _____ Group #: _____ Ph#: _____

Relationship to Patient: _____

Medical History

Are you currently under the care of a Physician/Specialist: ☐ Y ☐ N

Name: _____ Ph#: _____

If yes, please explain: _____

Have you been hospitalized for surgery or serious illness in the last 5 years? ☐ Y ☐ N

If yes, please explain: _____

Are you currently taking any prescription and/or over-the-counter drugs/supplements: ☐ Y ☐ N

Please List: _____

Have you ever had a head or neck injury? ☐ Y ☐ N

If yes, please explain: _____

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

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?



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 (PFD). 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 PFD 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 your 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 PFD, you recognize an obligation to promptly remit payment to PFD. _____ (patient initials)

PFD 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 PFD 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, PFD 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. **PFD 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 scheduled 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)

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 Evaluations 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 than 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 acknowledging 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 outlined 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 party 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.

-- continued --

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 law, 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: Routine Radiographs (x-rays) or Imaging, General Teeth Cleaning, Periodontal (Gum Tissue) Probing, Application of Topical Fluoride, Impressions for Study Casts, and/or Oral Cancer Screening.
_____ (patient initials)

By signing below, I authorize PFD to contact me via text, email or phone, as provided in my patient information profile for any lawful purpose. PFD is not responsible for any fees or charges I may incur from a phone, email or cellular carrier as a result of communication. By signing below, I acknowledge that I have read PFD'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 PFD 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 PFD and understand PFD will comply with HIPAA guidelines.

Printed Name of Patient _____

Patient Signature _____ Date _____

Legal Guardian or Representative Signature _____

Relationship to Patient _____ Date _____