West Valley Endodontics and Oral Surgery

New patients

Welcome to our practice. Our primary purpose is to serve you and your family, to provide for your dental health needs in a considerate and caring fashion. For your protection, this office has the most modern equipment, the latest techniques, above all, we follow OSHA guidelines in advanced sterilization technology for both staff and patient protection.

(Initials)_____

Consent for Services

As a Condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, and any dental services performed without previous financial arrangements, must be paid for in full at time services are preformed. I understand that the fee estimate listed for this dental care can only be extended for a period of **six** months from the date of the patient examination.

(Initials)_____

Medical and Dental Authorization

I have read the information on the health questionnaire and it is accurate to the best of my knowledge. I understand that the dentist to help determine appropriate and helpful dental treatment will use this information provided. If there are any changes in my medical status, I will inform the dentist.

(Initials)_____

Insurance Authorization

If you have dental insurance, we will gladly process your forms. However, we request that you pay your **estimated** portion when services are rendered. **Please remember that our contract for payment is with you and not your insurance carrier.** We are happy to bill your insurance as a courtesy to you, when you have provided us with your complete insurance information. We allow 45 days from the date of service for payment from an insurance company. After this period, we ask you to become responsible for payment of all unpaid fees.

(Initials)_____

Payment Options

Payment is due at the time of treatment. We accept cash, check, and all major credit cards. We also have two no interest payment plans, Care Credit and All Care, that allows you to start treatment today and spread payments over time. Applying for Care Credit and All Care only takes a few minutes and there is no fee to apply.

(Initials)_____

3D Imaging and Radiology Review Disclaimer

Our office utilizes 3D imagining, or Cone Beam Computed Tomography (CBCT), as part of our standard of care philosophy. These imagines contain valuable information regarding your anatomy, both concerning your specific reason for referral as well as occasional incidental findings. Due to the level of information these scans provide, our office requires that each scan be read by a radiologist. In addition to any fee quoted for the scan, there may be an additional fee assessed by the radiologist.

(Initials)_____

I HAVE READ THE ABOVE OFFICE POLICIES AND CONDITIONS OF TREATMENT AND AGREE TO THEIR CONTENT.

_____Date_____

Signature of patient, parent or guardian

PATIENT INFORMATION

Name_____ Birth date_____ SS#_____

Address_____ City_____ State _____ Zip_____

Sex _____M _____F ___Married_____Widowed___Minor___Single___Divorced

E-mail _____ Do we have your permission to email you our news letter ***YES / NO***

Home Phone _____Cell Phone _____

Pharmacy Info _____Pharmacy Phone _____

Pharmacy Address_____City _____ State ____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____Phone _____

I give_____ permission for West Valley Endodontics and Oral Surgery to communicate with them regarding my Dental treatment or any question regarding billing, and/or my appointments

Responsible Party

Name of Person
Responsible for this Account _____Relation to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthday_____

Employer _____ Work Phone _____

Dental Insurance Information

Name of Insured _____ Relation to Patient _____

Birthday _____ Social Security # _____Date Employed _____

Employer _____ Work Phone _____

Employer Address _____City _____State _____Zip _____

Insurance Company _____Group #_____

Address _____City _____ State _____ Zip _____

Insurance ID# _____ Insurance Phone _____

Medical Insurance Information

Name of Insured _____ Relation to Patient _____

Birthday _____ Social Security # _____Date Employed _____

Employer _____ Work Phone _____

Employer Address _____City _____State _____Zip _____

Insurance Company _____Group #_____

Address _____City _____ State _____ Zip _____

Insurance ID# _____ Insurance Phone _____

Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please circle your responses.

Health History Form

Patient's Name _____Date of Birth _____/_____/_____

Gender: Male / Female Height: _____Weight: _____ BMI_____

Please describe your current health: Excellent Good Fair Poor

Please describe the symptoms you are currently having today: _____

Have there been any changes in your general health in the past year? Yes No
If yes, please describe: _____

Are you now under a physician's care for a particular problem at this time? Yes No

If yes, why? _____Date of last physical exam ____/_____/_____
Have you ever been hospitalized or had a serious illness? Yes No
If yes, why?_____

Have you ever had surgery? Yes No

If yes, when and what for? Date of surgery:_____ Reason for surgery:_____

Date of surgery:_____ Reason for surgery:_____

PATIENT MEDICAL HISTORY
Do you have or have you ever had:

Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)?	Yes	No	Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?	Yes	No
Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)?	Yes	No	Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	Yes	No
Kidney disease or kidney failure, requiring dialysis?	Yes	No	Liver disease (jaundice, hepatitis A, B, or C)?	Yes	No
Thyroid disease?	Yes	No	Arthritis?	Yes	No
Stomach ulcers or colitis?	Yes	No	Significant weight loss or gain?	Yes	No
Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes	No	Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No
Frequent or recurring mouth sores?	Yes	No	Sinus or nasal problems?	Yes	No
Glaucoma?	Yes	No	Sleep apnea?	Yes	No
Diabetes?	Yes	No	Osteoporosis or osteopenia?	Yes	No

Any cancer, radiation, or chemotherapy? Yes No
Describe: _____Date of your last treatment? _____

Do you have any other disease, condition or problem <u>not listed above</u> that you think the doctor should know about?

If yes, please explain: _____

FAMILY MEDICAL HISTORY

Do you have a family history of any of the following? If yes, indicate the relationship.

Diabetes? Yes No Relationship _____

Cancer? Yes No Relationship _____

Heart disease? Yes No Relationship _____

Bleeding problems? Yes No Relationship _____

Tumors? Yes No Relationship _____

Lung disease? Yes No Relationship _____

FEMALE PATIENTS

Are you pregnant, or is there any chance you might be pregnant? Yes No

Patient's Name _____Date of Birth _____/_____/_____

MEDICATIONS

Are you using any of the following:

Antibiotics?	Yes	No	Prescription pain medication?	Yes	No
Anticoagulants (blood thinners)?	Yes	No	Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Insulin or oral anti-diabetic drugs?	Yes	No
Heart medications?	Yes	No	Blood pressure medications?	Yes	No
Steroids (cortisone, prednisone, etc.)?	Yes	No	Bisphosphonates, antiangiogenic and/or antiresorptive medications for osteoporosis, multiple myeloma or other cancers? If yes, list drugs used and time of use. _____ _____	Yes	No
Antianxiety agents, antidepressants or other psychiatric medications?	Yes	No			

Please list any specific medications indicated above and/or any other medications not listed above that you are currently taking including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals:

Medication	Dosage	Medication	Dosage

ALLERGIES

Are you allergic to or have you had an adverse reaction to:

Latex?	Yes	No	Codeine or other pain killers?	Yes	No
Food products?	Yes	No	Aspirin, Motrin, Aleve, or ibuprofen?	Yes	No
Sedatives, barbiturates?	Yes	No	Penicillin or other antibiotics?	Yes	No

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes No If yes, which anesthetic? _____ Relationship? _____

Other drug allergies not listed above: _____

SOCIAL HISTORY

Have you ever smoked or chewed tobacco? Yes No If yes, for how long? _____

Have you ever sought professional care or been hospitalized for:			**Do you use:**			
Substance abuse?	Yes	No	Alcohol?	Yes	No	How often? _____
Emotional disorders?	Yes	No	Marijuana?	Yes	No	How often? _____
Alcoholism?	Yes	No	Recreational drugs?	Yes	No	How often? _____

DENTAL HISTORY

Have you had any adverse effects from dental treatment? Yes No If Yes, please explain?_____

Do you wish to talk to the doctor privately about anything? Yes No

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible.

_____ _____

Signature of patient, parent, guardian Date

_____ _____

Printed name of patient, parent, guardian/Relationship Doctor's Signature

HEALTH HISTORY UPDATE

Date	Comments	Doctor's Signature
_____	_____	
_____	_____	

Authorization and Release

To the best of my knowledge, the information provided in this packet is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have change in health. I certify that I, and/or my dependent(s), have insurance coverage with _____ assign directly to **West Valley Endodontics and Oral Surgery** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I authorize the use of my signature on all insurance submissions. The above-named facility may use my health care information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient or Legal Guardian Print Patient Name Date

NOTICE OF PRIVACY PRACTICES
West Valley Endodontics and Oral Surgery

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment here at West Valley Endodontics and Oral Surgery is to serve our patients with professionalism and caring, being sure at all times to PROTECT the privacy and security of all Protected Health Information. During the course of serving your interests, it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where information may be shared:

- For payment purposes, we may use the services of a billing service.
- During dental care, we may need to consult with your physician or previous dentist.
- For payment purposes, we need to supply information requested from your dental insurances company.

We here at West Valley Endodontics and Oral Surgery are committed to obeying all Federal, State, and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. The individual, as provided by law, may revoke this written authorization at any time.

If you have any questions or comments regarding your Protected Health Information, feel free to contact our Compliance Officer: (623)444-4521.

I have read and understand the above Notice of Privacy Practices.

Signed: _____ Date: _____/_____/_____

(Patient or Legal Guardian)

Oral Surgery Financial & Scheduling Policies

Deposit amount

Our office requires a 25% deposit of your dental treatment cost with a $100 non-refundable deposit to reserve your appointment date, and it's due at the time of reserving your appointment. In which the deposit will be applied to your dental procedure.

Appointment reservation

You are welcome to make your reservation for surgery on the day of your consultation. If you later realize that work or other scheduling conflicts exist, your deposit will be fully credited toward a more convenient surgery date so long as 3 business day notice is given.

Rescheduling

In order to receive full credit for your deposit, please notify our office at least 3 business days prior to your scheduled procedure date. We understand that personal situations can arise unexpectedly, and you may reschedule your surgery as often as necessary without penalty provided we receive 3 business days advance notice.

Final Payment

Final payments must be received at the time of the surgical appointment.

The following policies have been designed to maintain an efficient surgery schedule and ensure the fair distribution of the doctor's surgery time for all patients. We hope the policies do not cause significant inconveniences and truly appreciate your cooperation. Thank you for placing your trust in West Valley Endodontics and Oral Surgery.

I certify that I have read this form, fully understand, and comply with the financial terms related to my surgical procedure.

Signature of Patient/Guardian _____ Date _____