Southwest
DENTAL ARTS

New Patient Paperwork

PATIENT INFO:

Patient Name:____________________________ Date of Birth:___/___/___

SSN:_____-_____-_____Cell Phone:___________ Home Phone:_____________

May we text you? Yes:___ No:___ Email:________________________________

Address:____________________ City:__________ State:_____ Zip:___________

Patient Employer:____________________

Marital Status: Single:___ Married:___ Widowed:___ Minor:___

Emergency Contact:____________________ Phone:______________

Relationship To Patient:__________________

DENTAL INSURANCE INFO:

Name of **Primary** Insurance:____

Subscriber ID #:____________________ Group #:_______________

Policy Holder Name:______________________________ Relation:____________

Policy Holder DOB:___/___/___ Policy Holder SSN:_____-_____-_____

Policy Holder Employer:_______________________ Employer Phone:_________

Name of **Secondary** Insurance:_______________________________________

Subscriber ID #:____________________ Group #:_______________

Policy Holder Name:______________________________ Relation:____________

Policy Holder DOB:___/___/___ Policy Holder SSN:_____-_____-_____

Policy Holder Employer:_______________________ Employer Phone:_________

*** Please email your insurance card to: info@southwestdentalboise.com prior to your appointment***

Communication (via Email and Texting) Consent:

This form is used to obtain your consent to communicate with you by email and texting regarding your Protected Health Information. Southwest Dental Arts offers patients the opportunity to communicate by email and texting. Transmitting patient information by email and texting has a number of risks that patients should consider before granting consent to use email and texting for these purposes. Southwest Dental Arts will use reasonable means to protect the security and confidentiality of email and texting information sent and received. However, Southwest Dental Arts cannot guarantee the security and confidentiality of email and texting communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email and texting between Southwest Dental Arts and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Southwest Dental Arts. I consent and accept the rick in receiving information via email and texting.

Patient Signature:____ Date:___________

Southwest
DENTAL ARTS

DENTAL HISTORY

GENERAL:

1. Who was your previous dentist? How long?___________________________________
2. Date of last Dental Exam:_______________ Last Cleaning:__________________
3. Do you have any immediate concerns you'd like us to address? Yes:____ No:____

If yes, what are they?____

____

PERSONAL:

1. Are you concerned about the appearance of your teeth? Yes No
2. Are you interested in improving your smile? Yes No
3. Have you had any cavities in the past 2 years? Yes No
4. Are any teeth sensitive to Biting, Sweets, Hot or Cold? Yes No
5. Do you avoid or have difficulty chewing or biting hard foods? Yes No
6. Do you have any problems sleeping, wake up with a headache, or with sore or sensitive teeth? Yes No
7. Do you clench your teeth in the daytime? Yes No
8. Do/Have you ever worn a bite appliance for clenching at night (nightguard) or for sleep apnea? Yes No
9. Do you bite your nails, Chew gum/pens, hold nails with your teeth or any other oral habits? Yes No
10. Does the amount of saliva in your mouth seem too little? Do you find yourself with a dry mouth often? Yes No
11. Have you ever noticed a consistently unpleasant taste or odor in your mouth? Yes No

STRUCTURAL:

1. Do your gums bleed when brushing or flossing? Yes No
2. Is brushing or flossing typically painful? Yes No
3. Have you ever experienced/been told you have Gum Recession? Yes No
4. Have you ever been treated for/been told you have Gum Disease? Yes No
5. Have you had any teeth removed for braces or otherwise? Yes No
6. Do you know of any missing teeth or teeth that have never developed? Yes No
7. Have you ever had braces, Orthodontic treatment, spacers, or had a bite adjustment? Yes No
8. Are your teeth becoming more crowded, overlapped, crooked? Yes No

Southwest
DENTAL ARTS

STRUCTURAL (cont.):

9. Are your teeth developing spaces? Yes No
10. Do you frequently get food caught between any teeth? Yes No
11. Have you noticed your teeth becoming shorter, thinner, or flatter over the years? Yes No
12. Do you have any problems with your jaw joint? Yes No
(popping, clicking, TMD, deviating from side to side when opening/closing)

OFFICE RELATIONSHIP:

1. On a scale of 1-5, with 5 being the most terrified, how fearful are you of dental treatment? (Please circle corresponding number) 1 2 3 4 5
2. Is there anything you'd prefer during your visits to make you more comfortable during your visit with us? ____

____

3. What do you value most in your dental visits? ____________________________

____

MEDICAL HISTORY

1. Do you have any of the following medical conditions listed below?

Condition		Condition		Condition	
AIDS/HIV Positive	Y N	Excessive Thirst	Y N	Mitral Valve Prolapse	Y N
Alzheimer's Disease	Y N	Epilepsy/Seizures	Y N	Osteoporosis	Y N
Angina	Y N	Excessive Bleeding	Y N	Psychiatric Care	Y N
Anaphylaxis	Y N	Frequent Diarrhea	Y N	Radiation Treatments	Y N
Anemia	Y N	Frequent Cough	Y N	Recent Weight Loss	Y N
Arthritis/Gout	Y N	Fainting/Dizziness	Y N	Rheumatic Fever	Y N
Artificial Joints	Y N	Glaucoma	Y N	Rheumatism	Y N
Artificial Heart Valve	Y N	Heart Attack/Failure	Y N	Renal Dialysis	Y N
Asthma or Emphysema	Y N	Heart Murmur	Y N	Sinus Trouble	Y N
Blood Disease	Y N	Heart Trouble/Disease	Y N	Sickle Cell Disease	Y N
Blood Transfusion	Y N	High Blood Pressure	Y N	Stroke	Y N
Cold Sore/Fever Blisters	Y N	Hay Fever	Y N	Scarlet Fever	Y N
Cortisone Medication	Y N	Hives/Rash	Y N	Stomach/Intestinal Disease	Y N
Convulsions	Y N	Hepatitis A, B, or C	Y N	Swelling Of Limbs	Y N
Cancer	Y N	High Cholesterol	Y N	Shingles	Y N
Chemotherapy	Y N	Hypoglycemia	Y N	Tumor or Growth	Y N
Chest Pain	Y N	Kidney Disease	Y N	Tonsillitis	Y N
Congenital Heart Disorder	Y N	Low Blood Pressure	Y N	Thyroid Disease	Y N
Diabetes	Y N	Leukemia	Y N	Tuberculosis	Y N
Drug Addiction	Y N	Lung Disease	Y N	Ulcers	Y N
Easily Wounded/Bruised	Y N	Liver Disease	Y N		

2. Have you had any serious illness that was not listed above? Yes No
If yes, which one(s):____
3. Are you currently being treated for any Neurological conditions? Yes No
If yes, which one(s):____
4. Are you on a special diet? Yes No
If yes, please describe:____
5. Have you been diagnosed with Sleep Apnea? Yes No
6. Do you use a CPAP machine while sleeping? Yes No
7. Do you snore or stop breathing while you sleep? Yes No
8. Do you use tobacco/controlled substances? Yes No
9. Are you currently taking any medications? Yes No
If yes, what are they? ____
____
10. Are you allergic to any medications? Yes No
If yes, what are they?____
____
11. **Women**, are you:
Trying to Conceive? Y N
Nursing? Y N
Taking oral contraceptives? Y N

PATIENT CONSENTS/AUTHORIZATIONS

Notice of Privacy Practices

By signing below, I acknowledge that I have Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

Patient Signature:_____________________________ Date:__________

HIPPA Authorization

I authorize the disclosure of information from my treatment record to:
Name of who we release information to:_____________________________
Relationship to the patient:_____________________________________
Patient Signature:____________________________ Date:__________

Financial Policy

Please remember that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits you have, questions concerning any pre-

treatment estimates, and/or fees for services or procedures. Please be aware that any balance is your responsibility whether or not your insurance company pays any portions.
Patient Signature:_______________________________________ Date:___________

Insurance
I certify that I (or my dependent) have insurance coverage with the listed insurance company and assign directly to Southwest Dental Arts all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Southwest Dental Arts to release all information neccessary to secure the payment of benefits. I authorize the use of my signature for all insurance submissions.
Patient Signature:______________________________________ Date:_______________

Payments
I understand that regardless of any insurance status, I am responsible for the balance due on my account. I am responsible for any and all professional services rendered. This includes, but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and any other services not directly provided by the dentist.
FULL PAYMENT is due at time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at time of service. Any unpaid balance over 90 days will be subject to a monthly interest of 1 ½ %. If payment is delinquent, the patient will be responsible for payment of collection, attorney fees, and court costs associated with the recovery of monies due on the account.
Patient Signature:____ Date:_________

Missed Appointment
Unless we receive notice of cancellation 48 hours in advance, you will be charged $50.
Patient Signature:____ Date:_________

Photo Release
I authorize Southwest Dental Arts to take photographs and/or images of my face, jaw, mouth, and teeth. I understand that these pictures will be mainly used as a record of my care, and may rarely be used for educational purposes in study meeting, lectures, and/or seminars. I further understand that if the photographs or images are used in any way, all in identifying information, including name, will be strictly kept confidential. I do not expect compensation, financial or otherwise, for use of these photographs.
Patient Signature:____ Date:_________