Southwest
DENTAL ARTS

1201 S. Five Mile Rd, Boise, ID 83709 Phone: 208-322-5655 Fax: 208-323-8160

New Patient Paperwork

Patient Name: _____Date of Birth: ____/___/___ SS #: _____-_____-_____
Email: _____Phone: _____Text ok? Yes❑ No❑
Address: _____City:_____State:_____Zip Code:_____
Check appropriate box: Minor❑ Single❑ Married❑ Divorced❑ Widowed❑ Separated❑
Emergency Contact:_____Phone:_____Relationship:_____

DENTAL INSURANCE INFO:

Name of PRIMARY insurance: _____Subscriber ID #:_____Group #:_____
Policy Holder Name:_____Policy Holder Birthdate:___/___/___Policy Holder SS #:___-___-___
Policy Holder Relation to Patient: Self❑ Spouse/Partner❑ Parent❑ Other❑

_____
Policy Holder Employer:_____Employer Phone:_____
Do you have additional insurance? Yes❑ No❑ (If Yes, please complete the following section)
Name of SECONDARY insurance: _____Subscriber ID #:_____Group #:_____
Policy Holder Name:_____Policy Holder Birthdate:___/___/___Policy Holder SS #:___-___-___
Policy Holder Relation to Patient: Self❑ Spouse/Partner❑ Parent❑ Other❑

_____
Policy Holder Employer:_____Employer Phone:_____

PRACTICE POLICIES AND PROCEDURES:

Appointment Fees:

We require notice of cancellation 48 business hours in advance to avoid a cancellation fee. Our cancellation fees range from $75 - $200 per hour. By initialing, the patient agrees to pay appointment fees if applicable. **Patient Initials: _____**

Notice of Privacy Practices:

By initialing, the patient acknowledges that they have Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPPA) **Patient Initials: _____**

Financial Policy:

Your insurance policy is a contract between you and your insurance company. It is up to you to contact your insurance company and inquire as to what benefits you have, and any questions regarding coverage for services or procedures. The patient certifies that they (or any dependents) have insurance coverage with the listed insurance company and assign directly to Southwest Dental Arts all insurance benefits. Patient authorizes Southwest Dental Arts to release all information necessary to secure the payment of benefits and authorize the use of their signature for all insurance submissions. Patient understands that they are financially responsible for all charges for services provided whether or not paid by insurance. **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 monthly interest. 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 Initials: _____

Photo Release:

I authorize Southwest Dental Arts to take photographs and/or images of my face, jaw, mouth, and teeth for record of my care. If the images are used in any way, all identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for use of these photographs. **Patient Initials: _____OR Decline❑**

Patient Medical History:

1. Are you under a physician's care now? Yes❑ No❑ If yes, who? _____
2. Are you taking any medications(including over the counter)? Yes❑ No❑ If yes, please list below:

_____

3. Have you been hospitalized for any surgical operation or serious illness in the last 10 years? Yes❑ No❑ If yes, please list year and it what it was below:

_____

4. Have you ever taken Fosamax, Actonel, or medication containing bisphosphonates? Yes❑ No❑
5. Have you been told you require antibiotic Pre-med prior to dental appointments? Yes❑ No❑
6. Are you on a special diet? Yes❑ No❑ If yes, please explain: _____
7. Do you use controlled substances? Yes❑ No❑ If yes, what ones:_____
8. Do you use tobacco? Yes❑ No❑ 9. Have you been diagnosed with Sleep Apnea? Yes❑ No❑
10. Do you use a CPAP while sleeping? Yes❑ No❑ 11. Do you snore or stop breathing when you sleep? Yes❑ No❑
12. Do you have any of the following Medical Conditions?

Angina Yes❑ No❑	Anaphylaxis Yes❑ No❑	AIDS/HIV positive Yes❑ No❑	Arthritis/Gout Yes❑ No❑
Artificial Heart Valve Yes❑ No❑	Ashthma/Emphysema Yes❑ No❑	Anemia Yes❑ No❑	Artificial Joints Yes❑ No❑
Chest Pain Yes❑ No❑	Easily Winded Yes❑ No❑	Blood Disease Yes❑ No❑	Cortisone Yes❑ No❑
Congenital Heart Disorder Yes❑ No❑	Frequent Cough Yes❑ No❑	Blood Transfusion Yes❑ No❑	Osteoporosis Yes❑ No❑
Heart Attack/Failure Yes❑ No❑	Hay Fever Yes❑ No❑	Bruise Easily Yes❑ No❑	Rheumatism Yes❑ No❑
Heart Murmur Yes❑ No❑	Hives/Rash Yes❑ No❑	Excessive Bleeding Yes❑ No❑	Swelling of Limbs Yes❑ No❑
Heart Trouble/Disease Yes❑ No❑	Lung Disease Yes❑ No❑	Hepatitis A, B, or C Yes❑ No❑	Cold Sores Yes❑ No❑
High Blood Pressure Yes❑ No❑	Sinus Trouble Yes❑ No❑	High Cholesterol Yes❑ No❑	Shingles Yes❑ No❑
Low Blood Pressure Yes❑ No❑	Diabetes Yes❑ No❑	Hypoglycemia Yes❑ No❑	Tonsillitis Yes❑ No❑
Mitral Valve Prolapse Yes❑ No❑	Excessive Thirst Yes❑ No❑	SickleCell Disease Yes❑ No❑	Thyroid Disease Yes❑ No❑
Cancer Yes❑ No❑	Recent Weight Loss Yes❑ No❑	Stroke Yes❑ No❑	Liver Disease Yes❑ No❑

Chemotherapy Yes❑ No❑	Fainting/Dizziness Yes❑ No❑	Rheumatic Fever Yes❑ No❑	Kidney Disease Yes❑ No❑
Leukemia Yes❑ No❑	Convulsions Yes❑ No❑	Scarlet Fever Yes❑ No❑	Renal Dialysis Yes❑ No❑
Radiation Treatment Yes❑ No❑	Epilepsy/Seizures Yes❑ No❑	Stomach/Intestinal Disease Yes❑ No❑	Tuberculosis Yes❑ No❑
Tumor or Growths Yes❑ No❑	Glaucoma Yes❑ No❑	Ulcers Yes❑ No❑	Drug Addiction Yes❑ No❑
Psychiatric Care Yes❑ No❑	Frequent Headaches Yes❑ No❑	Frequent Diarrhea Yes❑ No❑	Alzheimers Yes❑ No❑

13. Have you had any serious illness that was not listed above? Yes❑ No❑ If yes:

_____

14. *<u>WOMEN ONLY</u>* Are you: Trying to conceive?Yes❑ No❑ Nursing?Yes❑ No❑ Taking oral contraceptives?Yes❑ No❑

15. Are you allergic to any of the following: (please circle)

Aspirin Penicillin Codeine Latex Metal Acrylic Local Anesthetics Other _____

Dental Health:

Do your gums bleed? Yes❑ No❑ Are your teeth loose? Yes❑ No❑

Been diagnosed with gum disease? Yes❑ No❑ Are you concerned about bad breath? Yes❑ No❑

Are your teeth sensitive? Yes❑ No❑ Pain, clicking, or popping in jaw? Yes❑ No❑

Are you HAPPY with your smile? Yes❑ No❑ Do you clench or grind your teeth? Yes❑ No❑

Dental History:

Previous dentist?_____How long?_____Last Dental Exam:_____Last Cleaning:_____

Do you have any immediate concerns you'd like us to address? Yes❑ No❑

If yes, what are they?_____

Personal:

Are you concerned about the appearance of your teeth? Yes❑ No❑

If yes, are you interested in improving your smile? Yes❑ No❑

Have you had any cavities in the past 2 years? Yes❑ No❑

Are any teeth sensitive to Biting, Sweets, Hot or Cold? Yes❑ No❑

Do you avoid or have difficulty chewing or biting hard foods? Yes❑ No❑

Do you have any problems sleeping, wake up with a headache, or with sore or sensitive teeth? Yes❑ No❑

Do you clench your teeth in the daytime? Yes❑ No❑

Do/Have you ever worn a bite appliance for clenching at night (nightguard) or for sleep apnea? Yes❑ No❑

Do you bite your nails, chew on gum/pens with your teeth or any other oral habits? Yes❑ No❑

Does the amount of saliva in your mouth seem too little? Do you find yourself with a dry mouth often? Yes❑ No❑

Have you ever noticed a consistently unpleasant taste or odor in your mouth? Yes❑ No❑

Structual:

Do your gums bleed when brushing or flossing? Is brushing or flossing typically painful? Yes❑ No❑
Have you ever experienced/been told you have Gum Recession? Yes❑ No❑
Have you ever been treated for/been told you have Gum Disease? Yes❑ No❑
Have you had any teeth removed for braces or otherwise? Yes❑ No❑
Do you know of any missing teeth or teeth that have never developed? Yes❑ No❑
Have you ever had braces, Orthodontic treatment, spacers, or had a bite adjustment? Yes❑ No❑
Are your teeth becoming more crowded, overlapped, crooked? Yes❑ No❑
Are your teeth developing spaces? Yes❑ No❑
Do you frequently get food caught between any teeth? Yes❑ No❑
Have you noticed your teeth becoming shorter, thinner, or flatter over the years? Yes❑ No❑
Do you have any problems with your jaw joint? Popping❑ Clicking❑ TMD❑ None❑

Office Relationship:

On a scale of 1-5, with 5 being the most terrified, how fearful are you of dental treatment? _____
What do you value most in your dental visits? _____
Is there anything you'd prefer during your visit to make you more comfortable? _____
Anything else you would like us to know? _____

Thank you for completing your paperwork. Please return to the front desk.