Southwest
DENTAL ARTS

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:_____

How did you hear about us? _____

DENTAL INSURANCE INFO: (Skip if not applicable)

Name of insurance: _____Subscriber ID #:_____Group #:_____

Policy Holder Name:_____Policy Holder Birthdate: _____/_____/_____

Policy Holder SS #:_____

Policy Holder Relation to Patient: Self❑ Spouse/Partner❑ Parent❑ Other❑ _____

PRACTICE POLICIES AND PROCEDURES:

Appointment Cancellation Policy:
We kindly ask for at least 48 business hours' notice for any appointment cancellations or rescheduling. This allows us to offer the time to other patients in need of care. **Cancellations or missed appointments without sufficient notice may result in a fee ranging from $75 to $200 per scheduled hour**. By initialing below, I acknowledge and agree to this policy and understand that I may be charged a cancellation fee if proper notice is not provided.

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 (HIPAA). **Patient Initials: _____**

Financial Policy:
Your dental insurance policy is a contract between **you and your insurance company**. As a **courtesy**, Southwest Dental Arts may verify your benefits and provide an **estimation of costs** based on the information provided by your insurance. However, please note that this is **not a guarantee of coverage or payment. Final determination of benefits and payment is made solely by your insurance provider**. It is ultimately **your responsibility** to contact your insurance company with any questions about coverage, benefits, or limitations related to your plan. The patient certifies that they (or their dependents) have active dental insurance coverage with the listed insurance company and hereby assign all dental benefits directly to Southwest Dental Arts. The patient also authorizes Southwest Dental Arts to release any necessary information to secure payment of benefits and to use their signature on insurance claims. **Full payment is due at the time of service.** If insurance benefits apply, **estimated co-payments and any applicable deductibles are due at the time of treatment.** By initialing below, **I acknowledge and agree that I am financially responsible for all charges for services rendered at Southwest Dental Arts, regardless of whether my insurance pays, delays, or denies any portion of the claim.** In the event of a delinquent account, I understand I may be responsible for any applicable **collection costs, attorney fees, and court expenses**, as permitted by law. **Patient Initials: _____**

Consent for Electronic Communications:
I authorize Southwest Dental Arts to send me appointment reminders, billing statements, payment reminders, and other dental- related communications electronically, including via email or text. I understand that I can revoke this consent at any time by notifying the office. I also acknowledge that electronic communications may carry some privacy risks, and the office will take reasonable safeguards to protect my information. **Patient Initials: _____ OR Decline❑**

Patient Signature: _____ Date Signed: _____

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 for below:

_____

4. Have you ever taken Fosamax, Actonel, or medication containing bisphosphonates? Yes❑ No❑
5. Have you been told you require an 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❑

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 Yes❑ No❑	Anemia Yes❑ No❑	Artificial Joints Yes❑ No❑
Chest Pain Yes❑ No❑	Easily Winded Yes❑ No❑	Blood Disease Yes❑ No❑	Cortisone Yes❑ No❑
Congen. 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 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. **Women's Health Questions**

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❑
Been diagnosed with gum disease? Yes❑ No❑
Are your teeth sensitive? Yes❑ No❑
Are you HAPPY with your smile? Yes❑ No❑
Are your teeth loose? Yes❑ No❑
Are you concerned about bad breath? Yes❑ No❑
Pain, clicking, or popping in jaw? 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, waking 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?_____