PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: _____ Date of birth: _____ Sex: _____ Age: _____

Home address: _____ City: _____ State: _____ Zip: _____

Billing address (if different): _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____ E-mail: _____ Driver's license #: _____ State: _____

SS #: _____ Employer/Occupation: _____ Bus. Phone: _____

Spouse's name & phone #: _____ Emergency phone # (other than spouse): _____

Primary dental insurance: _____ Group #: _____

Secondary dental insurance: _____ Group #: _____

Subscriber's name: _____ Date of birth: _____ SS #: _____

Name of your medical doctor: _____ Date of last visit to medical doctor: _____

Name of previous dentist: _____ Date of last visit to dentist: _____

Referred to us by: _____ _____

DENTAL HEALTH HISTORY

	Yes	No
Are you apprehensive about dental treatment?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Do you gag easily?	☐	☐
Do you wear dentures?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have difficulty in chewing your food?	☐	☐
Do you chew on only one side of your mouth?	☐	☐
Do you avoid brushing any part of your mouth because of pain?	☐	☐
Do your gums bleed easily?	☐	☐
Do your gums bleed when you floss?	☐	☐
Do your gums feel swollen or tender?	☐	☐
Have you ever noticed slow-healing sores in or about your mouth?	☐	☐
Are your teeth sensitive?	☐	☐
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids?	☐	☐
Cold foods or liquids?	☐	☐
Sours?	☐	☐
Sweets?	☐	☐
Do you take fluoride supplements?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
Do you prefer to save your teeth?	☐	☐
Do you want complete dental care?	☐	☐

	Yes	No
How often do you brush?		
How often do you floss?		
Does your jaw make noise so that it bothers you or others?	☐	☐
Do you clench or grind your jaws frequently?	☐	☐
Do your jaws ever feel tired?	☐	☐
Does your jaw get stuck so that you can't open freely?	☐	☐
Does it hurt when you chew or open wide to take a bite?	☐	☐
Do you have earaches or pain in front of the ears?	☐	☐
Do you have any jaw symptoms or headaches upon awaking in the morning?	☐	☐
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?	☐	☐
Do you find jaw pain or discomfort extremely frustrating or depressing?	☐	☐
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?	☐	☐
Do you have a temporomandibular (jaw) disorder (TMD)?	☐	☐
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	☐	☐
Are you unable to open your mouth as far as you want?	☐	☐
Are you aware of an uncomfortable bite?	☐	☐
Have you had a blow to the jaw (trauma)?	☐	☐
Are you a habitual gum chewer or pipe smoker?	☐	☐

MEDICAL HEALTH HISTORY:

Do you have, or have you had, any of the following?

	Yes	No
Heart Problems	☐	☐
Chest pain	☐	☐
Shortness of breath	☐	☐
Blood pressure problem	☐	☐
Heart murmur	☐	☐
Heart valve problem	☐	☐
Taking heart medication	☐	☐
Rheumatic fever	☐	☐
Pacemaker	☐	☐
Artificial heart valve	☐	☐
Blood Problems	☐	☐
Easy bruising	☐	☐
Frequent nosebleeds	☐	☐
Abnormal bleeding	☐	☐
Blood disease (anemia)	☐	☐
Ever require a blood transfusion?	☐	☐
Allergy Problems	☐	☐
Hay fever	☐	☐
Sinus problems	☐	☐
Skin rashes	☐	☐
Taking allergy medication	☐	☐
Asthma	☐	☐
Intestinal Problems	☐	☐
Ulcers	☐	☐
Weight gain or loss	☐	☐
Special diet	☐	☐
Constipation/Diarrhea	☐	☐
Kidney or bladder problems	☐	☐
Bone or Joint Problems	☐	☐
Arthritis	☐	☐
Back or neck pain	☐	☐
Joint replacement (e.g., total hip, pins, or implants)	☐	☐
Fainting Spells, Seizures, or Epilepsy	☐	☐
Stroke(s)	☐	☐
Frequent or severe headaches	☐	☐
Thyroid problems	☐	☐
Persistent cough or swollen glands	☐	☐
Premedications required by physician	☐	☐
Cancer/Tumor	☐	☐

	Yes	No
Diabetes	☐	☐
Urinate more than 6 times a day	☐	☐
Thirsty or mouth is dry much of the time	☐	☐
Family history of diabetes	☐	☐
Tuberculosis or other respiratory disease	☐	☐
Do you drink alcohol?	☐	☐
If so, how much?		
Do you smoke?	☐	☐
If so, how much?		
Hepatitis, jaundice, or liver trouble	☐	☐
Herpes or other STD	☐	☐
HIV-positive/AIDS	☐	☐
Glaucoma	☐	☐
Do you wear contact lenses?	☐	☐
History of head injury?	☐	☐
Epilepsy or other neurological disease?	☐	☐
History of alcohol or drug abuse?	☐	☐

Do you have any disease, condition, or problem not listed previously that you feel we should know about?

If so, please describe: _____

Are you allergic, or have you reacted adversely, to any of the following?

	Yes	No
Local anesthetics ("Novocaine")	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Aspirin, Acetaminophen, or Ibuprofen	☐	☐
Codeine, Demerol, or other narcotics	☐	☐
Reaction to metals	☐	☐
Latex or rubber dam	☐	☐
Other		

Notes: _____

_____

_____ Date: _____

During the past 12 months, have you taken any of the following?

	Yes	No
Antibiotics or sulfa drugs	☐	☐
Anticoagulants (e.g., Coumadin)	☐	☐
High blood pressure medicine	☐	☐
Tranquilizers	☐	☐
Insulin, Orinase, or similar drug	☐	☐
Aspirin	☐	☐
Digitalis or drugs for heart trouble	☐	☐
Nitroglycerin	☐	☐
Cortisone (steroids)	☐	☐
Natural remedies	☐	☐
Nonprescription drug/supplements	☐	☐
Other		

Women	Yes	No
Are you taking contraceptives or other hormones?	☐	☐
Are you pregnant?	☐	☐
If so, expected delivery date:		
Are you nursing?	☐	☐
Have you reached menopause?	☐	☐
If so, do you have any symptoms?		

Notes: _____

_____

Patient/Parent Signature: _____

Dentist Initial: _____

Dakota Implant & Sedation Center

HIPAA Information & Consent

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy.

A notice of Privacy Practices should be available from the U.S. Department of Health and Human Services.

By signing below, you understand and agree to the terms of our notice pf privacy practices which include:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- Authorization is required for certain disclosures or your Protected Health Information.
- You have the right to opt out of fundraising communications.
- You have the right to restrict disclosures of your Protected Health Information under certain circumstances.
- You have the right to be notified of a breach of unsecured Protected Health Information.

By signing below, you understand and agree that:

- The practice has a Notice of Privacy Practices that you have had the opportunity to review.
- The practice reserves the right to change the Notice of Privacy Practices and if we change our notice, you may obtain a revised copy by contacting our office.
- You may revoke this consent in writing at any time and all future disclosures will cease.
- The practices may condition treatment upon the execution of this consent.

_____ ___/___/___

Signature of Patient or Guardian Date

Dakota Implant & Sedation Center

Authorization to Release Information To Others

Many of our patients allow family members or others close to them to call and request information regarding their condition and/or treatment. Under the requirements for HIPPA (Health Insurance Portability and Accountability Act), we are not allowed to give this information to anyone without the patient's consent. If you wish to have your dental condition and/or treatment disclosed to someone else, please indicate below. You have the right to revoke this consent, in writing, except where we have already made disclosures in compliance with your prior consent.

You do not need to list other medical professionals such as your medical doctor. List if you choose Spouses, parents & step-parents, family members, or significant others.

- o Yes. You May disclose my information to the below listed person(s)
- o No. You may not disclose my information to anyone but me

Approved Persons:

- Name:_____Relationship:_____
- Name:_____Relationship:_____
- Name:_____Relationship:_____

_____ ___/___/___

Signature of Patient or Guardian Date

_____

Printed Patient Name(s)-list any and all children

Dakota Implant & Sedation Center

Insurance Filing Policy

As a courtesy to our patients, we offer to file claims to in-network insurances on your behalf. As the insurance holder/patient covered under the plan, it is up to you to be aware of dental coverage, benefits, and how it is managed. We are in-network with over 100 insurance companies, each with their own separate plans and coverages. It is impossible for us to know everything about your plan. This form serves as an agreement with our office staff to do our best to utilize your insurance, get you the best coverage, and for you to understand that insurance is its own entity that you are responsible to have a general knowledge and understanding of.

1. If insurance information/card is not provided or cannot be verified, you will be expected to pay out of pocket in full for and procedure(s) day of.
2. Not all insurance plans cover 100% of procedures.
3. Dental insurance benefits are not determined by our office.
4. You are responsible to know about and pay for any co-pays & deductibles.
5. You are responsible for keeping the office up to date with changes to insurance.
6. Any estimate that our office staff provides to you is just that, an estimate.
7. Pre-determinations cannot be sent to insurance for plans under $1000 and take 4-6 weeks to process.
8. Any amount not covered by insurance is your responsibility, regardless of previous estimates.
9. Patient portion estimates are due date of service.
10. Our office can only work as fast as insurance, but we do our best to resolve claims and predeterminations as quickly as we can.

By signing this document, I agree to the above listed terms and do ask that Valley Dental provide me the courtesy of filing to my insurance on my behalf. Without signing, I agree to pay up-front for all procedures and file to insurance myself.

_____ ___/___/___

Signature of Patient or Guardian Date

Dakota Implant & Sedation Center

RELEASE OF INFORMATION

Please list your previous office name so that we may request your records

_____ may release my records to Valley Dental.

Previous Office Name

Please send patient(s) information to:

Dakota Implant & Sedation Center
1338 Gateway Drive South
Fargo, ND 58103
christa@valleydentalfargo.com
(701) 997-3967

_____ _____

List all patient names DOB(s)

_____ _____

Signature of patient/guardian Date

Dakota Implant & Sedation Center

Missed Appointment Policy

Dakota Implants has changed their policy on missed appointments.

We understand that there are emergencies, and things come up, and circumstances within reason will be considered. As of July 1st, 2022: We need a **48-hour** notice for any changes.

However, any missed appointments after this will require a ***non-refundable*** deposit to reserve another appointment time. We require ***ALL*** appointments to be confirmed either via our automated text messages- sent out 7 & 2 days prior, or through our confirmation calls-conducted at least 2 days before. If appointments are not confirmed, they will be cancelled with a final courtesy call.

Sedation appointments that are cancelled for any reason inside of the 48-hours will require a $500 deposit to reschedule.

It is the patient's responsibility that we have the most up-to-date and accurate contact information on file.

We send out multiple reminders to ensure you are aware of appointments, please give us the courtesy of confirming.

_____ ___/___/___

Signature of Patient or Guardian Date