DUSTIN D KARREN
GENERAL DENTISTRY

Welcome to our practice

Please take your time to fill out this form completely. The more we learn about you, the better care we are able to provide. We look forward to working with you to maintain a healthy, happy smile.

Patient Information

Patient Number _____

Today's date _____
First name _____ Middle initial _____ Last name _____
I prefer to be called (nickname, etc.) _____ ☐ Male ☐ Female
Address _____ City _____ State _____ ZIP _____
Date of birth _____ Social security no. _____
Home phone (___) ___ - _____ Work phone (___) ___ - _____ Cell phone (___) ___ - _____
Primary contact number (please check one) ☐ Home ☐ Work ☐ Cell Best time to call _____
Fax (___) ___ - _____ E-mail _____ Driver's license no. _____
Employer _____ Occupation _____
Whom may we thank for referring you? _____

Dental History

Reason for today's visit _____
Are you currently in pain? ☐ Yes ☐ No
If so, please describe: _____
Do you have any dental problems now? ☐ Yes ☐ No
If so, please describe: _____
Have you ever had trouble with a previous dental treatment? ☐ Yes ☐ No
If so, please describe: _____
Level of anxiety about seeing the dentist: (least) 1 2 3 4 5 (most)

Date of last dental exam _____ Date of last cleaning _____ Date of last full mouth X-rays _____
Procedure(s) done at last dental visit _____
Previous dentist's name _____
Phone (___) ___ - _____
Why are you changing dentists? _____

How often do you have dental examinations? _____ How often do you brush your teeth? _____
How often do you floss? _____ What type of bristles do you use? ☐ Hard ☐ Medium ☐ Soft
What other dental aids do you use? (Electric toothbrush, toothpick, etc.) _____

Do you require antibiotics before dental treatment?	☐ Yes	☐ No	Do you have frequent headaches?	☐ Yes	☐ No
Do your gums ever bleed?	☐ Yes	☐ No	Do you clench or grind your teeth?	☐ Yes	☐ No
Have you noticed any mouth odors or bad tastes?	☐ Yes	☐ No	Are your teeth sensitive to heat/cold?	☐ Yes	☐ No
Do you bite your lips or cheeks frequently?	☐ Yes	☐ No	Do you still have your wisdom teeth?	☐ Yes	☐ No

Have you ever had:

Periodontal disease/gum treatment	☐ Yes	☐ No	Discomfort in your jaw joint (TMJ/TMD)	☐ Yes	☐ No
Orthodontics treatment	☐ Yes	☐ No	Your teeth ground or bite adjusted	☐ Yes	☐ No
Oral surgery	☐ Yes	☐ No	Serious injury to the mouth or head	☐ Yes	☐ No
A bite plate or mouth guard	☐ Yes	☐ No			

If yes to any of the previous questions, please describe _____

Is there anything else about your past dental treatment(s) that you would like us to know? _____

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MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care right now? ○ Yes ○ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes, please explain; _____
Have you ever had a serious head or neck injury? ○ Yes ○ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ○ Yes ○ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○ Yes ○ No _____
Are you on a special diet? ○ Yes ○ No
Do you use tobacco? ○ Yes ○ No
Do you use controlled substances? ○ Yes ○ No

Women: Are you
Pregnant/Trying to get pregnant? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problem ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
			Yellow Jaundice ○ Yes ○ No

Have you ever had any serious illness not listed above? ○ Yes ○ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

HIPPA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you (the patient). The Notice contains a Patient Rights section describing your rights under the law (this may be requested at the front desk). You have the right to review our full Notice before signing Consent. The terms of our notice may change. If we change our Notice, you may obtain a copy by contacting our office.

You may have the right to request that we restrict protected health information about you that is used or disclosed for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The practice reserves the right to change the Notice of Privacy Policy.
- The patient has the right to restrict the use of their information.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent.

Information Sharing: Please list any individuals we can share your personal information other than healthcare providers.

Name: _____ Relationship:_____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

This HIPPA Consent/Sharing was signed by (signature) Today's Date

_____

Relationship to patient (if other than patient)

Dustin D. Karren D.M.D

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GENERAL DENTISTRY

Patient Financial Policy

Our Office wants all of our patients to be able to comfortably afford dental care. The goal of our financial policy is to assist you with your insurance and explain your financial responsibility.

Written Estimate

After examination and necessary x-rays, you will be given a written estimate of your treatment needs. Your specific treatment plan will be provided for your approval. A signed copy will also become apart of your dental record. Please don't hesitate to inquire about options or priorities as they apply to your dental health.

If You Have Dental Insurance

As a courtesy to you, we will assist you with submitting your claim forms. ALL APPLICABLE COPAYMENTS AND DEDUCTIBLES ARE TO BE PAID AT THE TIME OF SERVICE. Since insurance coverage is a contract between you and your insurance company, we cannot guarantee any estimated insurance coverage. You are responsible for your account, not the insurance company. The insurance company's restrictions, exclusions, or waiting periods may affect the predetermined, estimated or actual benefits paid.

If You Do Not Have Dental Insurance

Your treatment plan estimate will serve as a reminder of the costs of the specific services provided. These fees are due at the time of service unless prior arrangements have been made with the billing receptionist or the doctor. There is a discount to patients who do not have insurance.

Multiple Appointment Procedures

Extensive work such as crowns, bridges, dentures, vaneers, or orthodontics will usually take multiple appointments. Half of the patient's co-payment will be due at the start of the treatment and the final balance will be due at the end of treatment (depending on the number of appointments).

Payment Options

1. **Cash or Check is gladly accepted**
2. **Credit Card: Our office also accepts all major credit cards**
3. **Outside Financing is available**

***Payment not made for services after a reasonable period of time will be forwarded to a collection agency.**

****A $25 charge will be incurred for any checks returned for non-sufficient funds.**

By signing below, I understand and agree to the terms stated above. I have also received a copy of this agreement for my records.

Signed_____ **Date**_____

702 East Bell Road • Suite 110 • Phoenix, Arizona 85022 • (602) 482-3929 • Fax: (602) 867-0443

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Smile Analysis

Patient Name:_____ **Today's Date**_____

1. Do you love the way your smile look? ◯ Yes ◯ No

2. Do you feel comfortable showing your teeth when you laugh and smile? ◯ Yes ◯ No

3. If you could change anything about your smile, it would be (check all that apply):
◯ Color of your teeth ◯ Too much or too little of teeth show when you smile ◯ Gaps between your teeth
◯ Size/shape of your teeth ◯ Too much or too little of gum shows when you smile ◯ Alignment of your teeth
◯ Other:_____

4. Would you be interested in orthodontic treatment that could straighten your teeth in about 6 months?
◯ Yes ◯ NO

5. Do you have (check all that apply):
◯ Sensitive or receding gums ◯ Worn/Broken/chipped teeth ◯ Old or discolored fillings ◯ Missing teeth
◯ Old crowns that have dark edges at the top ◯ Other_____

6. In your line of work or lifestyle, do you (check all that apply):
◯ Visit businesses or clients ◯ Travel ◯ Speak publicly ◯ Other_____

7. If you had a smile makeover do you think you'd feel (check all that apply):
◯ More confident ◯ More optimistic ◯ Healthier
◯ Just OK ◯ No different ◯ Other :_____

8. Do you or someone in your family have issues with any of the following (check all that apply):
◯ Chronic bad breath ◯ Grinding teeth ◯ Snoring ◯ Other: _____

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