

## Thank You For Selecting Our Dental Healthcare Team!

*We will provide you with the finest possible dental care.  
 To help meet all your dental healthcare needs, please fill out this form completely.  
 If you have any questions or need assistance, please ask us - we are happy to help.*

### Patient Information (Confidential)

Patient Full Legal Name: \_\_\_\_\_ I prefer to be called: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Phone(s): \_\_\_\_\_  Y  N  
Cell/Mobile Phone Ok to receive text? Home/2<sup>nd</sup> Phone Work/Office Phone

\_\_\_\_\_ Email Address \_\_\_\_\_ Social Security Number \_\_\_\_\_ Birthdate (MM - DD - YYYY)

Employer: \_\_\_\_\_ Gender : \_\_\_\_\_

Whom do we have your permission to share your health & financial records with? \_\_\_\_\_

How did you learn about our office? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
Name Relationship Phone

### Dental Health History Your answers to this dental health questionnaire will help us to understand your specific dental situation, so that we may more effectively treat you with consideration for your individual needs.

Previous Dentist: \_\_\_\_\_ Date of Last Visit \_\_\_ / \_\_\_ / \_\_\_ Date of Last Complete Dental Exam \_\_\_ / \_\_\_ / \_\_\_.

What is your immediate dental concern? \_\_\_\_\_

Yes  No  1. Are you troubled with dryness in your mouth?

Yes  No  2. Have you had Periodontal treatment, gum surgery, Root Planning & scaling or "deep cleaning"?  
 When: \_\_\_\_\_ Where: \_\_\_\_\_ circle which treatment(s) was rendered

Yes  No  3. Have you been informed that you have gum problems?

Yes  No  4. Do your gums bleed when you brush your teeth or floss?

Yes  No  5. Does food catch between your teeth?

Yes  No  6. Are you aware of a bad taste or odor in your mouth?

Yes  No  7. Do your jaw muscles feel tired, stiff or painful?

Yes  No  8. Are you aware of—or have you been told of -clenching or grinding your teeth during the day?

Yes  No  9. Are you aware of—or have you been told of -clenching or grinding your during sleep?

Yes  No  10. Have you ever cracked or broken a tooth?

11. Which Items do you use daily? (**circle**) Hard bristle toothbrush - Soft bristle toothbrush - Electric toothbrush  
 Proxi-brush - Rubber tip - Dental floss - Waterpic - Other: \_\_\_\_\_

Please select **one** box on **each** line

My mouth is very comfortable       My mouth is moderately comfortable       My mouth is uncomfortable

My smile is excellent       I would like to change my smile       I am unconcerned about my smile

I will do whatever I must to keep my teeth       I want to keep my teeth & work within a budget of time & money

I've done the dentistry recommended to me       I've NOT done the recommended dentistry       Never been recommended

MY DENTAL HEALTH IS:     Excellent     Good     Fair     Poor

**Medical Health History**

Physician: \_\_\_\_\_ Dr. Office Phone: \_\_\_\_\_ Date of Last Exam: \_\_\_\_\_

*All drugs (including recreational drugs such as Cocaine, Marijuana, Stimulants or Depressants) may have a fatal interaction with local anesthetics or other common dental medications. Please describe the use of any drugs or discuss in complete confidentiality with the doctor.*

	Yes	No
Are you under medical treatment now? -----	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been hospitalized for any surgical operation or serious illness? -----	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking any medications? Including non-prescription herbs or supplements -----	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please list those medications: _____		
_____		

	Yes	No
Do you use tobacco/tobacco products (including e-cigs)	<input type="checkbox"/>	<input type="checkbox"/>
Are you allergic to, or have you had any reactions to the following?		
Local Anesthetics (e.g., novocaine) -----	<input type="checkbox"/>	<input type="checkbox"/>
Rubber or Latex -----	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other Antibiotics -----	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>

Do you use marijuana? -----	<input type="checkbox"/>	<input type="checkbox"/>
Do you use cocaine or other recreational drugs? -----	<input type="checkbox"/>	<input type="checkbox"/>

**Women Only**

Are you pregnant or think you may be pregnant? -----	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking birth control pills? -----	<input type="checkbox"/>	<input type="checkbox"/>

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

**PER CALIFORNIA LAW EACH QUESTION MUST BE MARKED INDIVIDUALLY**

	Yes	No
Alcohol or Drug Dependency ---	<input type="checkbox"/>	<input type="checkbox"/>
Anemia -----	<input type="checkbox"/>	<input type="checkbox"/>
Angina -----	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis -----	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valves -----	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints -----	<input type="checkbox"/>	<input type="checkbox"/>
Asthma -----	<input type="checkbox"/>	<input type="checkbox"/>
Cancer -----	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy -----	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes -----	<input type="checkbox"/>	<input type="checkbox"/>
Depression or Mood Conditions -	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy -----	<input type="checkbox"/>	<input type="checkbox"/>
Fainting -----	<input type="checkbox"/>	<input type="checkbox"/>
Gastric Reflux(GERD) / Heartburn	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Glaucoma -----	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/Surgery ---	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease -----	<input type="checkbox"/>	<input type="checkbox"/>
<i>Including Coronary Artery Disease/ Arteriosclerosis</i>		
Hepatitis -----	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure ---	<input type="checkbox"/>	<input type="checkbox"/>
HIV -----	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice -----	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease -----	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease -----	<input type="checkbox"/>	<input type="checkbox"/>
Organ Transplant -----	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis -----	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker -----	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged Bleeding ---	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Prolonged Cough -----	<input type="checkbox"/>	<input type="checkbox"/>
Radiation Therapy -----	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever -----	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Problems -----	<input type="checkbox"/>	<input type="checkbox"/>
Snoring (or told you snore) ---	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea -----	<input type="checkbox"/>	<input type="checkbox"/>
*If Yes, Did you try CPAP?	<input type="checkbox"/>	<input type="checkbox"/>
*Have you had a sleep study	<input type="checkbox"/>	<input type="checkbox"/>
Stroke -----	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease -----	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis -----	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers -----	<input type="checkbox"/>	<input type="checkbox"/>
STD/STI <i>incl</i> Herpes -----	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify) _____		

Please add anything you feel is important for us to know about your dental or medical history: \_\_\_\_\_

**Authorization and Release**

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. If I have any changes in my health, or if my medications change, I will inform the doctor at the next appointment. If deemed advisable, I grant permission for my physician to be contacted for details and advice.

I authorize the taking of radiographs, photographs, or other diagnostic measures appropriate for a thorough evaluation. I consent to any necessary services needed during diagnosis and treatment. I grant permission to use my diagnostic and treatment photographs, models and records for the purpose of display for scientific articles, seminars and presentations provided that my identity is not revealed.

I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

Signature of Patient (or Parent if Minor) \_\_\_\_\_

\_\_\_\_\_ Date

Doctor's Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Signature of Doctor \_\_\_\_\_ / / Date

Reviewed / Date Reviewed / Date Reviewed / Date Reviewed / Date Reviewed / Date Reviewed / Date Reviewed / Date



## Appointment & Financial Policies

### Appointment Policy

**Missed appointments, or those cancelled with less than 48 business hours of the scheduled appointment time, may be charged a \$50 missed-appointment fee**

- We believe that we can provide optimal dental care only if we have enough time to thoroughly examine your condition and discuss any treatment options. The same is true for treatment that has been scheduled.
- Your appointment is reserved exclusively for you. If you miss or fail to attend your appointment or cancel at the last moment, we will be unable to care for another patient. If you arrive 10 or more minutes late for your appointment, we may need to reschedule your appointment to allow us to stay on time for our other scheduled patients. This is considered a “missed appointment”.
- If you think that you may be late for your appointment, please call us as soon as possible so that we may advise you if your late arrival can be accommodated, or if we will need to reschedule your appointment and assess a fee. We respect your time as well, and in the event that we have unforeseen issues and will be running late, we will attempt to notify you. This is why we ask for the “best” number/manner to reach you on short notice.
- We realize that there can be circumstances beyond (y)our control and we always take that into consideration.

### Appointment Notification Protocol

- Our notification/reminder system will help you confirm upcoming appointments and provide efficient reminders. You may opt-out at any time.
- The information you provide us, such as email and cell phone numbers are a protected part of your health care record. We do not share nor release this information outside of this office. Your privacy is important to us.

**Please check your preferred method for automated Appointment Reminders:**

- Text Message       Email Message       Phone Message       NONE

### Financial Policy - Dental Benefit Plan Authorization & Release

***I authorize and request my Dental Benefit Plan (DBP/insurance) to assign benefits to Dr. Larsen***

I will pay my full payment or, if insured, my estimated co-insurance to Dr. Larsen at the time of my visit. If I have dental insurance, my Dental Benefit Plan (DMB/insurance) shall pay to Dr. Larsen. Any difference remaining between the estimated DPB coverage and actual payment made by my DBP will be invoiced (or reimbursed) to me upon completion of insurance processing, typically within 45 days from the date of service.

***I understand that my Dental Benefit Plan is an agreement between me (or my employer) and the DBP company carrier. My DBP may pay less than the actual bill or estimated portion for services and neither Dr. Larsen nor the DMB carrier can or will promise the ultimate insurance payment amount.***

**I have read, understand and agree to the Appointment & Financial Policies contained herein:** (Responsible Party)

Our office, as most businesses, requires payment in full for all services rendered at the time of visit. If you have a Dental Benefit Plan, we are pleased to be able to provide DBP claim filing services to you, and as a courtesy, you may have the DBP pay the office directly.

*You may pay for services using cash, personal check, Visa/MC, Discover & American Express.  
Additionally, we offer CareCredit™ as an alternative for monthly payments if you qualify.*

In the event a balance remains on account more than 45 days, balance is subject to 1.0% interest monthly, limited to 12% per year. If account is not paid within 60 days of the date of service (including dental benefit plan portion, if applicable). The undersigned will be responsible for legal fees, collection agency fees, interest charges, late fees and any other expenses incurred in collecting past-due account.

\_\_\_\_\_  
Responsible Party Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**NOTICE OF PRIVACY PRACTICES**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

**You have the Right to:**

- \* Get a copy of your medical record
- \* Correct your medical record
- \* Request confidential communication
- \* Ask us to limit information we share
- \* Get a copy of this privacy notice
- \* Choose someone to act for you
- \* Get a list of those with whom we've shared
- \* File a complaint if you believe your privacy rights have been violated

**Your Choices:**

- You have some choices in the way that we use & share information as we:*
- \* Tell Family & Friends about your condition
  - \* Provide disaster relief
  - \* Include you in a hospital directory
  - \* Provide Mental Health Care
  - \* Raise Funds
  - \* Market our services & sell our information

**Our Uses and Disclosures:**

- We may use & share your information as we:*
- \* Treat you
  - \* Run our organization
  - \* Bill for your services
  - \* Help with public health & safety
  - \* Do research
  - \* Comply with the law
  - \* Respond to organ/tissue requests
  - \* Respond to lawsuits/legal actions
  - \* Address workers' compensation, law & government agencies

**NOTICE OF DENTAL MATERIALS**

I understand that, according to the Dental Board of California (Business and Professions Code 1648.10-1648.20), I must have the opportunity to review a Dental Materials Fact Sheet (ON THE BACK OF THIS PAPER). I understand that this information:

- Contains information regarding Allergic reactions, Safety and Toxicity to Dental Materials.
- Addresses Advantages and Disadvantages to a variety of Dental Materials.
- Instructs me to talk to my dentist and ask questions regarding dental materials so that I may make an informed choice.

*The durability of any dental restoration is influenced not only by the material it is made from but also by the dentist's technique when placing the restoration. Other factors include the supporting materials used in the procedure and the patient's cooperation during the procedure. The length of time a restoration will last is dependent upon your dental hygiene, home care, diet and chewing and biting habits. ....  
www.dbc.ca.gov*

I have received, read and understand the **Notice of Privacy Practices AND Notice of Dental Materials**.

I understand that this organization has the right to change its **Notice of Privacy Practices AND Notice of Dental Materials** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the **Notice of Privacy Practices AND Notice of Dental Materials**.

PRINT Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ (if not signed by Patient)

**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement of this Notice of Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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## Dental Materials Summary Fact Sheet

### Allergic Reactions to Dental Materials

Components in dental fillings may cause reactions just like other materials we come into contact with in our daily lives. The risk of such reactions is very low for all types of filling materials and there are no documented cases of allergic reactions to composite resin, glass ionomer, resin ionomer or porcelain. If you have allergies, discuss filling materials with your dentist.

### Toxicity of Dental Materials

*Dental Amalgam* – not used in this office

Mercury in its *elemental* form is on the State of California's Prop 65 list of chemicals known to the State to cause reproductive toxicity. The FDA and other public health organizations have investigated the safety of amalgam used in dental fillings and there is no valid scientific evidence that has shown harm to patients with amalgam dental restorations (except rare allergy.)

*Composite Resin*

Some Composite Resins include Crystalline Silica, which is on the State of California's Prop 65 list of chemicals known to the State to cause cancer.

### Advantages

Strong & durable  
Tooth colored  
Resists breaking  
Maximum amount of natural tooth preserved  
Frequency of repair or replacement is low to moderate

Reasonably good esthetics  
May provide some help against decay  
Low incidence of tooth sensitivity

Very Good esthetics  
May provide some help against decay  
Good resistance to leakage

Resistant to surface wear-can cause wear on opposing teeth  
Good resistance to further decay  
Resists leakage because it can be shaped for accurate fit  
Does not cause tooth sensitivity

Good resistance to further decay with proper fit  
Very durable, due to metal substructure  
Resists leakage, no tooth sensitivity caused

Good resistance to further decay with proper fit  
Excellent durability, does not fracture under biting pressure  
Does not corrode, resists leakage

### Disadvantages

#### *Composite Resin (tooth colored) Fillings*

Moderate occurrence of tooth sensitivity  
Costs more than dental amalgam  
Material can shrink or leak over time  
May wear faster than surrounding natural tooth  
Requires more than one visit for inlays & crowns

#### *Glass-Ionomer Cement*

Cost is similar to Composite Resin  
Limited Use-not for biting surfaces in permanent teeth  
Does not wear well- cracks and becomes rough

#### *Resin-Ionomer Cement*

Cost is similar to Composite Resin  
Limited Use-not for biting surfaces in adults  
Wears faster than Composite Resin

#### *Porcelain (Ceramic)*

Material is brittle and can break under biting forces  
May not be recommended for all teeth/patients

#### *Porcelain fused to Metal (PFM)*

More tooth must be removed (than Porcelain)

#### *Gold Alloy*

Is not tooth colored  
Conducts heat and cold, may irritate sensitive teeth  
Cost can be higher than Porcelain or PFM