ERICKSEN DENTAL

1010 E. University Dr., Mesa, AZ 85203
480-644-7777
www.ericksendental.com

Welcome!

We are pleased to welcome you to our practice. Please take a few minutes to fill out our forms as completely as possible. If you have any questions, we are happy to help. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Patient Name: _____ D.O.B: _____
last , first
Status: Single/Child/Married/Other Sex: F/M
Social Sec.#: _____ - _____-_____ ID/Driver's License: _____
Address _____ City,State _____ Zip _____
Home Phone: _____ Cell: _____
E-mail: _____
Employer: _____ Work Phone: _____
** Emergency Contact: _____ Phone: _____

PRIMARY INSURANCE

Subscriber Name: _____ D.O.B: _____ Sex: F/M
last , first
Relationship Status: _____ Social Sec.#: _____ - _____-_____
Address (If different from patient) _____
City,State _____ Zip _____
Home Phone: _____ Cell: _____
E-mail: _____
Employer: _____ Work Phone: _____
Insurance Company: _____ Phone: _____
ID#: _____ GRP#: _____

How did you hear of us? _____

Reason for leaving your last dentist _____
_____

Dental & Medical History

Date of your last dental visit? _____ What would you like us to do today? _____
Are you having any discomfort at this time? ❑YES ❑NO Does dental treatment make you nervous? ❑No ❑Slightly ❑Moderately ❑Extremely
Do you brush ❑YES ❑NO How often do you brush? _____ Brush is: ❑Soft ❑Medium ❑Hard
Do you use the following? Dental Floss ❑YES ❑NO Fluoride Rinse ❑YES ❑NO, Other _____
Have you ever been treated for any type of gum problems? ❑YES ❑NO
How would you rate your dental health? ❑Excellent ❑Good ❑Poor
Are you happy with the appearance of your teeth? ❑YES ❑NO *If no, what would you change?*_____

DO YOU HAVE ANY OF THE FOLLOWING? ❑YES ❑NO Bleeding/sore gums ❑YES ❑NO Bad Breath.
❑YES ❑NO Food stuck in teeth ❑YES ❑NO Loose teeth ❑YES ❑NO Shifting in bite ❑YES ❑NO Clenching/grinding
❑YES ❑NO Sensitive to cold ❑YES ❑NO Sensitive to hot ❑YES ❑NO Sensitive to sweet ❑YES ❑NO Headaches
❑YES ❑NO Clicking/popping jaw ❑YES ❑NO Sensitive to biting ❑YES ❑NO Biting cheeks/lips ❑YES ❑NO Ortho/Braces

Is patient currently taking any medications? List all:
_____
_____

Does patient have any drug allergies? List all:
_____
_____

Have you ever used a bisphosphonate medication? (Fosamax, Actonel, Atelvia, Didronel and Boniva) ❑YES ❑NO
Have you ever taken Fen-Phen/Redux? ❑YES ❑NO

WOMEN: Are you pregnant ❑YES ❑NO Nursing ❑YES ❑NO Taking birth control ❑YES ❑NO

ANY HISTORY OF: (please mark yes or no)

❑YES ❑NO Anemia ❑YES ❑NO Arthritis/Rheumatism ❑YES ❑NO Artificial Joints ❑YES ❑NO Tested Positive for HIV /AIDS
❑YES ❑NO Asthma ❑YES ❑NO Allergies ❑YES ❑NO Back Problems ❑YES ❑NO Artificial Heart Valves
❑YES ❑NO Blood Disease ❑YES ❑NO Bronchitis Cancer ❑YES ❑NO Blood Transfusions ❑YES ❑NO Chemical Dependency
❑YES ❑NO Chemotherapy ❑YES ❑NO Cough, Persistent ❑YES ❑NO Cortisone or ACT II ❑YES ❑NO Circulatory Problems
❑YES ❑NO Diabetes ❑YES ❑NO Epilepsy/Convulsions ❑YES ❑NO Fainting/Dizzy Spells ❑YES ❑NO Fever Blisters/Herpes
❑YES ❑NO Glaucoma. ❑YES ❑NO Headaches ❑YES ❑NO Heart Murmur ❑YES ❑NO Heart Problems
❑YES ❑ NO Hepatitis ❑YES ❑NO Herpes ❑YES ❑NO Heart Valve Problem ❑YES ❑NO Hemophilia/Abnormal Bleeding
❑YES ❑NO High Blood Pressure ❑YES ❑NO Jaw Pain ❑YES ❑NO Lung Disease ❑YES ❑NO Kidney or Liver Disease
❑YES ❑NO Nervous Problems ❑YES ❑NO Nose Obstruction ❑YES ❑NO Psychiatric Care ❑YES ❑NO Mitral Valve Prolapse
❑YES ❑NO Shingles ❑YES ❑NO Radiation Treatment ❑YES ❑NO Rapid Weight gain/loss ❑YES ❑NO Pacemaker/Heart Surgery
❑YES ❑NO Shortness of Breath ❑YES ❑NO Rheumatic Fever ❑YES ❑NO Respiratory Disease ❑YES ❑NO Sinus Trouble
❑YES ❑NO Skin Rash ❑YES ❑NO Stroke ❑YES ❑NO Surgical Implant ❑YES ❑NO Tobacco Habit
❑YES ❑NO Thyroid Problems ❑YES ❑ NO Tonsillitis ❑YES ❑NO Swelling of Feet or ankles ❑YES ❑NO Tuberculosis
❑YES ❑NO Ulcers/Colitis

CONSENT

I have answered all questions to the best of my knowledge. If further information is needed, you have my permission to ask my respective health care provider or agency who may release such information to you. I will notify this office of any changes in my health or medication. The undersigned hereby authorizes this office to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. Upon such diagnosis, I authorize this office to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I understand that using anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. All diagnostic aids and documentation are the property of this office. Original records may not be taken by the patient. All records are strictly confidential. Signing this form authorizes us to transfer records to another dentist. I have reviewed a copy of this office's Notice of Privacy Practices and I have been notified that I may have a copy.

Patient _____ Date _____ Witness _____
Parent or Responsible Party _____ Relationship to Patient _____

ERICKSEN DENTAL

ACKNOWLEDGEMENT

The previously stated information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that may have made in the completion of the form.

Signature _____ Date _____

INSURANCE ASSIGNMENT AND RELEASE

I the undersigned, have insurance with_____and assign directly to Dr. David Ericksen all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signature _____ Date _____

MINOR/CHILD CONSENT

I, being the parent or guardian of_____do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to x-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Signature _____ Date _____

FINANCIAL POLICY

Payment is expected at time of treatment. We will gladly bill insurance as a courtesy; however, most insurance companies do not provide 100% of your payment. You are responsible for any charges not covered by your insurance. We do not extent payments unless prior arrangements have been made by our office manager. Finance charges of 1.5% will be added to any account over 60 days. In the event your account is turned over to an outside collection agency for non-payment or other delinquency, you will be responsible for payment of any collection cost and /or attorney fees, in addition to the balance owed.

Signature _____ Date _____

APPOINTMENT POLICY

Failed appointments are a significant contributor to rising healthcare cost. We require 24-hour notice for any appointment that you are unable to keep. A $50 fee will be charged to your account if you miss or cancel without the required 24 hours

Signature _____ Date _____

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Mesa, Az. 85203
480-644-7777

NOTICE OF PRIVACY ACT

(Full version of Privacy Act notice available at patient request)

We are required by law to maintain the privacy of your protected health information and to provide you with this notice, which explains our legal duties and privacy practices with respect to your protected health information. We must abide by the terms set forth in this notice. However, we reserve the right to change the terms of this notice and to make the new notice provisions effective for all protected health information we maintain. We will post and revised notice in a prominent location in our office and ,upon request, will provide to you a copy of the revised notice.

_____ _____

Print Name Date

_____ _____

Signature Date

For office use only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices but acknowledgment could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgment
- Other (please Specify)

_____

_____

This form does not constitute legal advice, and cover only federal, not state, law in effect or proposed as of August 14,2002

Consent for Composite (White) Fillings:

What is a composite filling and what are its benefits?
When a tooth has sustained a small localized area of decay or breakage, it can be repaired by a number of restorative options such as composite. Composite is a white or tooth-colored material that when used with an adhesive agent can bond to a tooth. By placing a composite filling a damaged tooth can be repaired with the intent to regain function and esthetics.

What are its risks?

1. **Retreatment or need for a nerve-treatment/crown/extraction:** After all decay has been removed and a tooth has been fixed with composite, it is the patient's responsibility to brush, floss, and limit frequent sweet and carbohydrate intake, otherwise new decay can form around the completed composite. In this case, the tooth may need to be retreated with a crown, nerve treatment/crown, or even extraction. Financial responsibility of ANY re-treatment is the patient's responsibility.
2. **Sensitivity of Teeth:** Often after preparation of teeth for the placement of any restoration, the prepared teeth may exhibit sensitivity. The sensitivity may be mild to severe. The sensitivity may last only for a short period of time or may last for much longer periods of time. If such sensitivity is persistent or lasts for much extended periods of time, I agree to notify the dentist as this may be a sign of more serious problems.
3. **Need for Nerve Treatment:** Teeth after being filled may develop a condition known as pulpitis or pulpal degeneration. This happens approximately 5% of the time. Every effort is made by the dentist to reduce this from happening, but since teeth contain vital tissue the pulp may become irreversibly inflamed. This may even occur when the tooth had no previous history of being sensitive. Should a root canal become necessary the procedure and its fees are the responsibility of the patient.
4. **Risk of Fracture:** Inherent in the placement or replacement of any restoration is the possibility of the creation of small fracture lines in tooth structure. Sometimes these fractures may not be apparent at the time of removal of tooth structure and/or the previous filling and placement or replacement, but may manifest at a later time.
5. **Esthetics or Appearance:** Effort will be made to closely approximate the natural tooth color. However, since a synthetic material is being used to replace natural enamel and dentin, there may not be an exact match. Also, over a period of time, the composite fillings, because of mouth fluids, different foods eaten, etc. may cause the shade to change. The dentist has no control over these factors.
6. **Breakage, or dislodgment:** Due to biting pressures or other traumatic forces, it is possible for composite resin fillings or esthetic restorations bonded with composite resins to be dislodged or fractured.

What are my alternatives?
As stated above other filling materials exist such as crowns. They too have benefits and risks. As always, choosing not to have treatment is an option but does carry negative consequences such as progressing decay, weakening of tooth structure, future pain and discomfort, packing food, space-loss, need for more extensive treatment, etc.

I, _____ understand that it is my responsibility to notify this office should any unexpected problems occur or
if any problems relating to the treatment rendered are experienced. Routine examinations by the dentist are recommended to allow ongoing
assessment of the composite treated tooth.

INFORMED CONSENT: I have been given the opportunity to ask questions regarding the nature and purpose of sealants and have received answers to my satisfaction. I voluntarily undergo this treatment in hopes of achieving the desired results from the treatment rendered though no guarantees have been made regarding the outcome. I hereby assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment. The fee(s) for these services have been explained to me and I accept them as satisfactory. By signing this form, I am freely giving my consent to authorize
Dr. Ericksen and/or all associates involved in rendering the services or treatment necessary to the existing dental condition, including the administration and/or prescribing of any anesthetic agents and/or medications.

_____

_____ **Patient's name (please print)**

_____Signature of legal guardian

_____Date

APPOINTMENT REMINDERS

Please circle all sources in which you would like to receive appointment reminders and provide the information needed to contact you. Thanks!

Phone Call **Text Message** **Email**

#:_____ Home or Cell?

Email:_____

We use this information to provide you with excellent treatment. We may disclose patient health information (PHI) to third parties that perform services for Ericksen Dental in the administration of your benefits in accordance with HIPAA. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Our affiliates do not email or send other forms of communication without user information and do not send spam.

Please sign below that you agree to allow us to use this information in providing your services.

X_____ Signature

X_____ Print

Date:_____

PATIENT'S NAME : _____

TODAY'S DATE : _____

Dear Patient,

In effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISITS.

We now offer the following payment options:

_____ Cash
_____ Check
_____ Debit/Credit Card (we accept VISA, MASTERCARD, DISCOVER & AMERICAN EXPRESS)
_____ Care Credit

Please make your choice, sign below and return to Office Manager before any treatment.

Our office is fully approved and accredited user of the *Visa and MasterCard Health Care Program* which will enable you to use your *Visa and MasterCard* to automatically cover your dental expenses.

If none of the above apply, please see the Office Manager, thank you!

Print Name: _____

Signed: _____

Dated: _____

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