DONALD REID D.D.S.
DENTAL ARTISTRY

Golden Rule
PATIENT CARE

Greetings

You have made a great choice choosing our practice for your care. We are committed to addressing your immediate concerns and also are prepared to manage your lifetime goals for optimal dental health.

Whether your desire is simply to eat in comfort, repair or replace broken and missing teeth, or to have an amazing smile; we are the right dental home for you.

Every patient in our practice has unique desires and needs. We will take the time to listen carefully, examine thoroughly and provide you the answer(s) that will meet your goals and exceed your expectations. Our team of professionals stand ready to deliver the dentistry you deserve in a relaxing atmosphere. We welcome you!

Sincerely,

Donald Reid, DDS

Donald Reid D.D.S. Dental Artistry
10330 Donner Pass Rd, STE A Truckee California 96161
703-212-9622 www.tahoedentalartistry.com

PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS IS FOR YOU START HERE

PATIENT INFORMATION

DATE:			
LAST NAME	FIRST		M.I.
ADDRESS			
CITY	STATE		ZIP
HOME PHONE NO.		WORK NO.	
SOCIAL SECURITY NO.			
CELL PHONE NO.	E-MAIL ADDRESS		
BIRTH DATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE		
RELATIONSHIP TO PATIENT		BIRTH DATE
SOCIAL SECURITY NO.		
ADDRESS		
CITY	STATE	ZIP
HOME PHONE NO.	CELL/WORK NO.	
EMPLOYER'S NAME		
EMPLOYER'S ADDRESS		

INSURANCE INFORMATION

Name of Carrier			
ADDRESS			
CITY	STATE		ZIP
Phone #		Group #	
Policy #	Policy Holder's Name		
Date of Birth	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED

YOUR SPOUSE INFORMATION

NAME
OCCUPATION
EMPLOYER'S NAME
EMPLOYER'S ADDRESS
HOME PHONE NO.
CELL/WORK NO.
Birthday Date:

GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?			
NAME:	RELATIONSHIP TO PATIENT		
YOU WERE REFERRED TO US BY:			
PERSON TO CONTACT FOR EMERGENCY:			
PHONE NUMBER			
ADDRESS	CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU			
PHONE NUMBER			
ADDRESS	CITY	STATE	ZIP

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I_____, have been advised of the Privacy Policies of the office and understand that I have the right to request a copy of the Notice of Privacy Practices.
Notice of our Privacy Practices is also available at www.tahoedentalartistry.com

CONSENT FOR TREATMENT

- I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of _____ dental needs.
  (***Patient's Name***)
- Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
- I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
- I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
- I give Dr. Reid's office permission to forward any and all x-rays to a referring doctor when necessary.

Patient Signature _____ Date_____

Witness Signature _____ Date_____

Parent/Guardian Signature_____ Relationship to Patient_____

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FINANCIAL POLICY

Dental treatment has been proven to be directly linked to the individual's overall medical and psychological wellbeing. We make every effort to remove financial considerations as an obstacle for this important health services.

PAYMENT INFORMATION

Patients are responsible for payment at the time of services.

If you need to make other financial arrangements with our office we are always ready to work with you.

Our office will be more than happy to complete your insurance claims and submit them to your Insurance Company. The claim reimbursement and /or explanation of benefits will be sent directly to the subscriber of the insurance policy.

FINANCE CHARGES AND COLLECTION ISSUES

A monthly interest rate of 1.5% will be applied to any unpaid balance, regardless of pending insurance after 30 days.

If a balance is in default and more forcible or thorough means are deemed necessary to collect, the undersigned agrees to pay, in addition to the total balance due and all applicable finance charges, all third party collection company fees, and /or attorney's fees of up to an additional 50% of the total balance outstanding at the time this matter is turned over to a collection company and /or attorney for collections; in addition to these fees, and all court costs, filing fees, processing fees and the like.

- I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made in writhing prior to treatment.
- If required, I also understand a check of my credit history may be required.
- Any returned checks from the bank are subject to a $35.00 dollar charge.

BROKEN APPOINTMENTS

Your appointment time is reserved exclusively for you. We strive to keep on time for all of our clients. If we are running behind we will try and call you ahead of time. We ask if you have any changes with your appointment you would notify us. We require 48 hours' notice to avoid broken appointment fee of $50.00 per ½ hour.

Patient Signature _____ Date_____

Witness Signature _____ Date_____

Parent/Guardian Signature_____ Relationship to Patient_____

NAME:	COMPLETE MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? If yes, for what? _____ Physician's Name: _____ Phone: _____ Address: City: State: Zip:	Yes	No
3. Are you taking any medication, including herbs, vitamins and over-the-counter medications? Please List: _____	Yes	No
4 **Have you been told you need to take antibiotics prior to dental treatment:**	Yes	No
5 Have you ever taken Bisphosphonates (Fosamax, Actonel or Boniva)? Are you still taking the medication? Yes_____ No_____ How long did you take it for?	Yes	No
6 Are you aware of having an allergic (or adverse) reaction to any medication or substance? _____ If yes, please list:	Yes	No
7 Have you been a patient in the hospital during the past 6 months? _____ If yes, please list:	Yes	No

8 Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A B C (circle)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact Lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

9 Have you been told you are a LOUD snorer?	Yes	No
10 Has someone told you, or have you noticed yourself, that you wake up gasping for air?	Yes	No
11 Have you ever been diagnosed with high blood pressure (hypertension)?	Yes	No
12 Have you had a sleep study? If yes, list diagnosis:	Yes	No
13 Have you been told to use a CPAP?	Yes	No
If yes, are you able to wear your CPAP consistently?	Yes	No
14 Do you have dry mouth? If yes, list suspected reason:	Yes	No
15 Please list any disease, condition, or problem not listed:		
16 **WOMEN:** Are you pregnant or think you may be pregnant? Yes No Months:_____ Nursing? Yes No		
17 **WOMEN:** Do you use birth control medications? Yes No		

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the dentist of any changes in my health or medication.

PATIENT/GUARDIAN SIGNATURE: DATE:

History Review

Dentist Signature _____ Date: _____

Dental History

Medical Alert

Patient's Name_____

What is the reason for your visit today? _____

Date of your last dental visit? _____ Last Dental Cleaning? _____ Full Mouth X-rays?_____

What was done at your last dental visit? _____

Previous Dentist's Name_____

Address _____State_____ Zip_____ Phone_____

How often do you have Dental Examinations? _____

How often do you brush your teeth? _____How often do you floss your teeth? _____Do you use Dental Aids? _____

(Example: interplak, toothpick)

Do you have any dental concerns at this time? _____

If yes, please describe: _____

Are any of your teeth sensitive to hot or cold?	Yes-No	Have you ever had orthodontic treatment?	Yes-No
Are any of your teeth sensitive to sweets?	Yes-No	Have you ever had oral surgery?	Yes-No
Are any of your teeth sensitive to biting or chewing?	Yes-No	Have you ever had periodontal treatment?	Yes-No
Have you noticed any mouth odors or bad tastes?	Yes-No	Have you ever had your teeth ground or bite adjusted?	Yes-No
Do your gums bleed or hurt?	Yes-No	A bite plate or mouth guard?	Yes-No
Have your parents experienced gum disease?	Yes-No	Have you ever had a serious injury to your mouth or head?	Yes-No
Have your parents experienced tooth loss?	Yes-No	If yes please describe, with cause.	
Have you noticed any loose teeth?	Yes-No		
Have you noticed any change in your bite?	Yes-No	Have you experienced clicking or popping in the jaw?	Yes-No
Does food get caught between your teeth?	Yes-No	Have you had any pain in: joint, ear, side of face?	Yes-No
If yes, where? _____		Do you have difficulty in opening or closing your mouth?	Yes-No
Do you:		Do you have difficulty in chewing on either side?	Yes-No
Clench or grind your teeth while awake or asleep?	Yes-No	Do experience headaches, neck aches, shoulder aches?	Yes-No
Bite your lips or cheeks regularly?	Yes-No	Sore muscles in neck, shoulders or face?	Yes-No
Hold foreign objects with your teeth? (Pencils, pipe, pins, nails, fingernails)	Yes-No	Are you satisfied with your teeth's appearance?	Yes-No
Mouth breathe while awake or asleep?	Yes-No	Would you like to keep all you teeth all your life?	Yes-No
Snore or have any other sleeping disorders?	Yes-No	Do you feel nervous about having dental care?	Yes-No
Smoke/chew tobacco or use any other tobacco products?	Yes-No	If so, is this your biggest concern?	Yes-No
		Have you ever had an upsetting dental experience? If yes, please describe _____	Yes-No

Is there anything else about having dental treatment that you would like us know? _____

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Date _____/_____/_____

Authorization for Release of Dental Records and X-rays

I _____, hereby authorize the release of records
(print patient or guardian name)

concerning _____ dental health and copies of all x-rays.
(patient name (s)

Patient's D.O.B._____

Previous Dental Provider:

Doctor's Name: _____

Street Address: _____

City, State, Zip _____

Phone: Email

Please forward to:
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Truckee, CA 96161
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Signed Patient or Guardian _____