

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

1

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATI	ENT INFORMAT	ION					
٨	DATE:						
	LAST NAME	FIRST		M.I.			
FOR YOU START	ADDRESS						
HERE	CITY	ZIP					
V	HOME PHONE NO.		WORK NO.				
	SOCIAL SECURITY NO.						
	CELL PHONE NO.	E-MAIL ADD	RESS				
	BIRTH DATE	AGE	MALE	FEMALE			
	MARRIED	SINGLE	DIVORCED	WIDOWED			
	INSURANCE INFO	RMATION					

ACCOUNT II	NFORM	IATION			
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 IN	FORMATION		YOUR SPOUSE INFORMATION				
Name of Carrie		NAME	NAME				
ADDRESS				OCCUP	OCCUPATION		
CITY	STATE	ZIP	EMPLOY	EMPLOYER'S NAME			
Phone # Group #				EMPLOY	EMPLOYER'S ADDRESS		
Policy #	Policy Hold	ler's Name		HOME PHONE NO.		5	
Date of Birth	AGE	MALE	FEMALE	CELL/W	CELL/WORK NO.		
MARRIED SINGLE DIVORCED			WIDOWED	Birthday	Birthday Date:		
GETTING TO	KNOW YOU						
IS ANOTHER ME	EMBER OF YOU	R FAMILY OR I	RELATIVE A PA	TIENT AT OUP	R OFFICE?		
NAME:			RELATIONSHI	P TO PATIEN	Г		
YOU WERE REF	ERRED TO US	BY:					
PERSON TO CO	NTACT FOR EM	ERGENCY:					
PHONE NUMBE	R						
ADDRESS		CITY		STATE	ZIP		
CLOSEST RELA	TIVE NOT LIVIN	G WITH YOU					
PHONE NUMBE	R						
ADDRESS			CITY		STATE	ZIP	



10330 Donner Pass Rd. STE A Truckee, CA 96161 703-212-9622

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 <u>www.tahoedentalartistry.com</u>

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

If yes, for what? Phone:: Adress: City: State:: Zip:	1.	1. Have you been under the care of a medical doctor during the past two years?					Yes	No		
Address: City: State: Zip: 3. Are you taking any medication, including herbs, vitamins and over-the-counter medications? Yes No Plesse List: Yes No 4 Have you ever taken Bisphosphonates (Fosamax, Actonel or Boniva)? Yes No Are you aware of having an allergic (or adverse) reaction to any medication or substance? Yes No 11 yes, please list: 7 Have you been a patient in the hospital during the past 6 months? Yes No 11 yes, please list: 8 Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item. Yes No 15 Indicate which of the following you have had, or have at present. Yes No Heaptitis A 10.5 Yes No 16 yes, please list: 8 Indicate which of the following you have had, or have at present. Yes No At 0.5 Yes No 16 yes, please list: 9 No Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item. Yes No 16 yes, please list: 11 yes, please list: 10 Distribution Yes No At 0.5 Yes No									_	
3. Are you taking any medication, including herbs, vitamins and over-the-counter medications? Yes No Please List:									_	
Please List:			223						╤	
4 Have you been told you need to take antibiotics prior to dental treatment: Yes No 5 Have you suill taking the medication? Yes No How long did you take it for? 6 Are you suill taking the medication? Yes No How long did you take it for? 7 Have you been a patient in the hospital during the past 8 months? Yes No 17 Have, please list: Yes No Hores, please list: 8 Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item. Heart (Surger, Disease, Attack) Yes No Congenital Heart Disease Yes No Ulcers Yes No Heart Surger, Disease, Attack) Yes No Hores No ALD S. Yes No Congenital Heart Disease Yes No Conduct Lenses Yes No Hore Surger Yes No ALD S. Yes No High Bood Pressure Yes No Conduct Lenses Yes No Have Yes No Hore Surger Yes No Have Yes No	3.	Are you taking any medication, inclu	uding I	nerbs, vi	tamins and over-the-	counter	medications	?	Yes	No
5 Have you ever taken Bisphosphonates (Fosamax, Actonel or Boniva)? Are you still taking the medication? Yes No Hou long did you take it for? Yes No 6 Are you sware 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? Yes No 11 Ity es, please list: Yes No 8 Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item. Mear (Surger, Disease, Attack) Yes No Diabetes Yes No Heat Marmar Cheet Pain Yes No Diabetes Yes No Heat Marmar Yes No Heat Marmar Yes No Congenital Heart Disease Yes No Cold Sores/Fever Blisters Yes No High Bood Pressure Yes No Cond Sores/Fever Blisters Yes No Heat Marmar Yes No Chorison Martial Water Prolapse Yes No Chorison Martial Water Prolapse Yes No Heart Markar Valee Yes No No Elsever Yes No Articial Heart Valee Yes No Chorison Martial Water Prolapse Yes No Chorison Martial Water Prolapse Yes No No Elseve No Socid Sores/Fever Blisters		Please List:					3			
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6 Are you aware of having an allergic (or adverse) reaction to any medication or substance? Yes No 7 Have you been a patient in the hospital during the past 6 months? Yes No 1 Hear (Surger, Disease, Attack) Yes No Hites, Please list: 8 Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item. Hear (Surger, Disease, Attack) Yes No Chest Pain Yes No Diabetes Yes No Attocid Pressore Yes No Congenital Hear Disease Yes No Congenital Hear Disease Yes No Attocid Pressure Yes No Congenital Hear Disease Yes No Congenital Hear Disease Yes No Attocid Pressure Yes No Condorman Yes No Condorman Yes No Condorman Yes No Condorman Yes No Attocid Hear Valve Yes No Condorman Yes No Attocid Hear Valve Yes No Liver So No Attocid Hear Valve Yes No Liver So No Heare Valve Yes <td>5</td> <td>Have you ever taken Bisphosphonates</td> <td>(Fosan</td> <td>nax, Acto</td> <td>nel or Boniva)?</td> <td></td> <td></td> <td></td> <td>Yes</td> <td>No</td>	5	Have you ever taken Bisphosphonates	(Fosan	nax, Acto	nel or Boniva)?				Yes	No
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7 Have you been a patient in the hospital during the past 6 months? Yes No If yes, please list: 8 Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item. 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 Uners Yes No Congenital Heart Disease Yes No Thyroid Problems Yes No Attack Yes No Heart Murrur Yes No Congenital Heart Disease Yes No Bloot Transfusion Yes No High Blood Pressure Yes No Contact Lenses Yes No Bloot Transfusion Yes No Artificial Heart Valve Yes No Chronic Cough Yes No Bloot Transfusion Yes No Rheumatic Fever Yes No Attrificial Heart Disease Yes No Bloot Transfusion Yes No Cortisone Medicine Yes No Attrificial Jonita (the problem and transfusion Yes No No Bloot Transfusion	6	Are you aware of having an allergic	(or ac	lverse) r	eaction to any medica	ation or	substance?		Yes	No
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Arthritis/Rheumatism Yes No Hay Fever Yes No Liver Disease Yes No Cortisone Medicine Yes No Altergies or Hives Yes No Yellow Jaundice Yes No Swollen Ankles Yes No Altergies or Hives Yes No No Neurological Disorders Yes No Stroke Yes No Radiation Therapy Yes No Epilepsy or Seizures Yes No Arthritis/Rheumatism Yes No Reliepsy or Seizures Yes No Epilepsy or Seizures Yes No Stroke Yes No Reliepsy or Seizures Yes No Epilepsy or Seizures Yes No Arthritical Joints (hip, knee, etc.) Yes No Chemotherapy Yes No Nervous/Anxious Yes No 10 Has someone told you, or have you noticed yourself, that you wake up gasping for air? Yes No 11 Have you been told to use a CPAP? Yes No 11 Have you been diagnosed with high blood pressure (hypertension)? Yes							10002000			
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Artificial Joints (hip, knee, etc.) Yes No Chemotherapy Yes No Nervous/Anxious Yes No 9 Have you been told you are a LOUD snorer? Yes No Psychiatric/Psychological Care Yes No 10 Has someone told you, or have you noticed yourself, that you wake up gasping for air? Yes No No Psychiatric/Psychological Care Yes No 11 Have you been told you, or have you noticed yourself, that you wake up gasping for air? Yes No 1 Yes No 12 Have you been told to use a CPAP? Yes No Yes No 1 Yes No 13 Have you been told to use a CPAP? Yes No Yes No 14 Do you have dry mouth? If yes, list suspected reason: Yes No 1 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:		Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	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 10 Have you been told you, or have you noticed yourself, that you wake up gasping for air? Yes No 11 Have you been told to use a LOUD snorer? Yes No 12 Have you been told to use a CPAP? Yes No 13 Have you been told to use a CPAP? 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: Yes No 16 WOMEN: Are you use birth control medications? Yes No Months: Yes No 17 WOMEN: Do you use birth control medications? Yes No Months: Yes No 16 WOMEN: Do you use birth control medications? Yes No Months: Yes No 17 WOMEN: Do you use birth control medicatio				2012/2020				Fainting or Dizzy Spells		
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 14 Do you have dry mouth? If yes, list suspected reason: 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: Image: the state of the s				202025			0.05			
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 14 Do you have dry mouth? If yes, list suspected reason: 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: Yes No 16 WOMEN: Are you pregnant or think you may be pregnant? Yes No Months:		Kidney Trouble Yes No Tumors Yes No Psychiatric/Psychological Care Ye						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 14 Do you have dry mouth? If yes, list suspected reason: 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: Yes No 16 WOMEN: Are you pregnant or think you may be pregnant? Yes No Months:	9	Have you been told you are a LOUD sn	orer?					1	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 14 Do you have dry mouth? If yes, list suspected reason: Yes No 15 Please list any disease, condition, or problem not listed: Yes No 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 Months: Nursing? Yes No 11 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										
12 Have you had a sleep study? If yes, list diagnosis: Yes No 13 Have you been told to use a CPAP? 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: Yes No 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 Months: Nursing? Yes No 19 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. DATE: History Review History Review History Review History Review	-						-			
13 Have you been told to use a CPAP? 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: Yes No 16 WOMEN: Are you pregnant or think you may be pregnant? Yes No Months:	11	11 Have you ever been diagnosed with high blood pressure (hypertension)?					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: Yes No 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 Months: Nursing? 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. DATE: History Review	12	12 Have you had a sleep study? If yes, list diagnosis:					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: Image: State of the state of	13	Have you been told to use a CPAP?	?						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 No 17 WOMEN: Do you use birth control medications? Yes No No 18 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		If yes, are you able to wear your CP	AP co	nsistent	ly?				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 No 17 WOMEN: Do you use birth control medications? Yes No No 18 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	14							Yes	No	
16 WOMEN: Are you pregnant or think you may be pregnant? Yes No Months:										
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							Manula	NiinO	Vee	Nie
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History Review		will notify the dentist of any changes in my health or medication.								
History Review		PATIENT/GUARDIAN SIGNATURE: DATE:								
Dentist Signature Date:		nistory review								
Dentist SignatureDate:Date:										
		Dentist Signature					Date:		-	

Dental History

	Patient's Name		Medical Alert	
	What is the reason for your visit today?			
			ing? Full Mouth X-rays?	
	Previous Dentist's NameSt		Zip Phone	
	How often do you have Dental Examinations? How often do you brush your teeth? How Do you have any dental concerns at this time? If yes, please describe:	often do yo	DU floss your teeth?Do you use Dental Aids? (Example: interplak, toothpick)	
~~~ ~	Are any of your teeth sensitive to hot or cold? Are any of your teeth sensitive to sweets? Are any of your teeth sensitive to biting or chewing? Have you noticed any mouth odors or bad tastes? Do your gums bleed or hurt? Have your parents experienced gum disease? Have your parents experienced tooth loss? Have you noticed any loose teeth? Have you noticed any change in your bite? Does food get caught between your teeth? If yes, where? Do you: Clench or grind your teeth while awake or asleep? Bite your lips or cheeks regularly? Hold foreign objects with your teeth? (Pencils, pipe, pins, nails, fingernails) Mouth breathe while awake or asleep? Snore or have any other sleeping disorders? Smoke/chew tobacco or use any other tobacco products?	Yes-No Yes-No Yes-No Yes-No Yes-No Yes-No Yes-No Yes-No Yes-No Yes-No Yes-No Yes-No Yes-No Yes-No Yes-No Yes-No Yes-No	<ul> <li>Have you ever had orthodontic treatment?</li> <li>Have you ever had oral surgery?</li> <li>Have you ever had periodontal treatment?</li> <li>Have you ever had your teeth ground or bite adjusted?</li> <li>A bite plate or mouth guard?</li> <li>Have you ever had a serious injury to your mouth or head?</li> <li>If yes please describe, with cause.</li> <li>Have you experienced clicking or popping in the jaw?</li> <li>Have you had any pain in: joint, ear, side of face?</li> <li>Do you have difficulty in opening or closing your mouth?</li> <li>Do experience headaches, neck aches, shoulder aches?</li> <li>Sore muscles in neck, shoulders or face?</li> <li>Mould you like to keep all you teeth all your life?</li> <li>Do you feel nervous about having dental care?</li> <li>If so, is this your biggest concern?</li> <li>Have you ever had an upsetting dental experience?</li> <li>If yes, please describe</li> </ul>	Yes-No Yes-No Yes-No Yes-No Yes-No Yes-No Yes-No Yes-No Yes-No Yes-No Yes-No Yes-No Yes-No Yes-No Yes-No Yes-No Yes-No

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

# DENALD REIDDS DENTAL DAREIDDS

Date _____/ ____/ _____/

### Authorization for Release of Dental Records and X-rays

(print patient or guardian name)	, hereby authorize the release of records
concerning(patient name (s)	dental health and copies of all x-rays.
Patient's D.O.B	
Previous Dental Provider:	
Doctor's Name:	
Street Address:	
City, State, Zip	
Phone:	Email
Pleas	se forward to:
Donald Reid	D.D.S. Dental Artistry
10330 Doi	nner Pass Rd. STE A
Trucl	kee, CA 96161
703	3-212-9622

Signed Patient or Guardian