Gold Canyon Dentistry

Comprehensive Care for Your Smile

New Patient Information Form

Patient Name: _____ Date: _____

First MI Last

Gender: M / F Social Security *(required if using insurance)*: _____ Birth Date: _____

Mobile: _____ Home: _____ Email: _____

Address: _____

City: _____ Zip: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

How did you hear about our office?

_____

_____

Insurance Information

Primary Insurance Plan Name: _____

Name of Subscriber: _____ Subscribers Birth Date: _____

ID #: _____ Group #: _____ Subscriber's Employer: _____

Patient's relationship with Subscriber: ☐ Self ☐ Spouse ☐ Child

Secondary Insurance Plan Name: _____

Name of Subscriber: _____ Subscribers Birth Date: _____

ID #: _____ Group #: _____ Subscriber's Employer: _____

Patient's relationship with Subscriber: ☐ Self ☐ Spouse ☐ Child

Patient Name: _____ Date: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV
- ☐ Allergy to medication
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Artificial Valves
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Clicking/Popping Jaw
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Endocarditis
- ☐ Excessive Bleeding
- ☐ Migraine
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever/Seasonal
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Sinus Problems
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

OTHER:

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

Have you ever taken any of the following? ☐ Bisphosphonates ☐ Blood Thinners

Please list ALL current medications:

_____

_____

_____

Please list any ALLERGIES to medications:

_____

_____

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

_____ Date: _____
Signature of Provider

UPDATED HEALTH HISTORY REQUIRED ONCE EVERY 12 MONTHS. NEW FORM REQUIRED EVERY THREE YEARS

_____ Date: _____
Signature of patient, parent or guardian

_____ Date: _____
Signature of Provider

_____ Date: _____
Signature of patient, parent or guardian

_____ Date: _____
Signature of Provider

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ acknowledge that I received and reviewed Gold Canyon Dentistry Privacy Policy Notice.

Patient's Signature: _____ Date: _____

Missed Appointment Policy

Due to the high number of patients requiring dental care, waiting times for appointments can be long. **Because of this, we ask that you allow 24 hours minimum for cancelled appointments, failure to do this, or "No Show" appointments will be charged a fee of $55.** Thanks for your cooperation helping offer appointments in a timely manner.

Signature: _____ Date: _____

Financial Agreement

This office is happy to cooperate with individuals who have dental insurance. Our office will file your claims with your dental insurance carriers. Your dental insurance company is under contract with you and your employer. We ask that you read your policy and understand all limitations of your benefits. Please call your insurance agent if you have any questions. YOU ARE ultimately responsible for cost related to your care.

If you have dual insurance, YOU are responsible for making sure you know which one is primary carrier and which one is secondary carrier. If you are unsure which one is primary at the time of your visit, we will collect the total from you and hold off on submitting to your insurance until you can verify the primary carrier. Please keep in mind that having dual insurance does not guarantee zero payment from you as the patient, as many insurances have non-duplication clauses. It is your responsibility to understand the clauses of your insurance policies before the time of your visit.

- The fees charged to insured individuals are our Usual and Customary Fees.
- If you do not have insurance, you will be expected to pay in full at time of service. We accept MC, Visa, American Express, Discover, Care Credit, Personal Check, and Cash.
- **We require your co-payment on the day of your dental services as contracted by your insurance provider. If you are non-insured, we require your signed and agreed upon patient portion on the day of your services.**
- If your insurance company fails to pay or rejects your claim, we require you to pay the balance in full and seek reimbursement from your insurance company.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

Parent/Guardian Information (if patient is a minor):

Name: _____ Relationship: _____

Phone number: _____ Email: _____

Address: _____

Signature: _____ Date: _____

General Informed Consent

Patient Name: _____ Date: _____

I. General Consent for Examination, Diagnosis, and Basic Procedures:

I, the undersigned patient (or legal guardian), hereby consent to the performance of dental examinations, diagnostic procedures (including X-rays as deemed necessary by the dentist), professional cleanings (prophylaxis), and other basic dental care by Gold Canyon Dentistry and/or their licensed associates, dental hygienists, and dental assistants at Gold Canyon Dentistry.

I understand that the initial visit typically involves:

- Comprehensive Oral Examination: To assess my overall oral health.
- Dental X-rays: To diagnose conditions not visible during a visual exam (e.g., decay between teeth, bone loss, infections). I understand the minimal risks associated with dental X-rays, including radiation exposure.
- Oral Cancer Screening: A visual and tactile examination of my mouth, head, and neck.
- Professional Cleaning (Prophylaxis): Removal of plaque and tartar.
- Treatment Planning: Based on the findings, the dentist will discuss my diagnosis, recommended treatment options, and alternatives.

II. Understanding of General Dental Care:

I authorize Dr. and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetics may cause an untoward reaction or side effects, which may include, but are not limited to, bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally, drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment, items including, but not limited to, crowns, small dental instruments, drill components, etc., may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal. I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen.

I understand that during my general dental care, the following may occur:

- Sensitivity: Teeth and gums may experience temporary sensitivity to hot, cold, or pressure, especially after cleanings, X-rays, or minor restorative procedures.
- Discomfort/Soreness: Mild discomfort or soreness in the jaw, gums, or teeth can occur following dental procedures.
- Local Anesthesia: For certain procedures, local anesthesia will be administered to numb the area. I understand the common risks associated with local anesthesia, including temporary numbness (lips, tongue, face), swelling, bruising, and rarely, allergic reaction or trismus (difficulty opening the mouth).
- Changes to Treatment Plan: Dental conditions can sometimes be more extensive than initially apparent. I understand that the treatment plan may need to be adjusted or expanded based on findings during treatment (e.g., discovery of deeper decay, need for root canal therapy after a filling).
- Emergencies: In rare instances, unforeseen emergencies may arise during treatment, and I authorize the dental team to take necessary actions to ensure my safety and well-being.
- Referrals: If specialized care is needed, I may be referred to a dental specialist.

III. Patient Responsibilities:

I understand the importance of:

- Providing accurate and complete medical and dental history information.
- Notifying the dental office of any changes to my health, medications, or allergies.
- Following all pre- and post-treatment instructions.
- Maintaining good oral hygiene at home (brushing, flossing).
- Attending scheduled appointments and returning for follow-up care as recommended.
- Communicating any concerns, pain, or unusual symptoms to the dental team promptly.

I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of nonhealing of the jaw bones following oral surgery or tooth extractions.

IV. No Guarantees:

I understand that dentistry is not an exact science. While our team strives for the best possible outcomes, no guarantees can be made regarding the success, longevity, or specific results of any dental treatment.

V. My Questions:

I have had the opportunity to ask questions regarding my general dental care, examinations, diagnostic procedures, and this consent form. All my questions have been answered to my satisfaction. I understand the information provided and give my informed consent for the dental services described.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me, if necessary, and I have been given the opportunity to ask questions.

_____ Date: _____

Signature of patient, parent or guardian

_____ Date: _____

Signature of Provider