CANYON ECHO DENTAL
DR. SUSIE WORM, DMD

WELCOME

The benefits of a happy, healthy smile are immeasurable!
Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely.
The better we communicate, the better we can care for you.

1 ABOUT YOU

Name _____

Preferred Name _____ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Birthday ___/___/___ Age ____ SS # ___-___-____

Address _____

City _____ State _____ Zip _____

Email _____

Home # _____ Work # _____

Mobile # _____ Fax # _____

Whom may we thank for referring you? _____

Other family members seen by us _____

Employer _____ Employer Ph.# _____

Employer Address _____

SPOUSE INFO

Name _____

Home # _____ Work # _____

Mobile # _____ Birthdate ___/___/___

Email _____

2 ACCOUNT INFO

PERSON RESPONSIBLE FOR ACCOUNT

Name _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Relation _____ ☐ Male ☐ Female

Home # _____ Work # _____

Birthday ___/___/___ Mobile # _____

Email _____

Billing Address _____

City _____ State _____ Zip _____

3 INSURANCE

Provider Name _____

Provider Address _____

City _____ State _____ Zip _____

Phone # _____

Group # _____

ID # _____

Insured's Name _____

Insured's Birthdate _____

Insured's Employer _____

Insured's Ph # _____

Insured's SS # _____

*ID# is sometimes different than SS#

IF YOU HAVE A SECONDARY INSURANCE PLEASE LET A TEAM MEMBER KNOW.

4 REMINDER INFO

We know your life is busy and we value your time. Please list a daytime phone number to help us remind you of upcoming appointments.

Home/Work/Cell # _____

5 EMERGENCY INFO

IN THE EVENT OF AN EMERGENCY, WHO SHOULD WE CONTACT?

Name _____ Relation _____

Home # _____ Work # _____

Thank you for filling out this form completely. It will allow us to serve you more effectively. If you have a question at any time, please ask us. We are happy to help!

6 MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name _____

Phone # _____ Last visit date _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain _____

_____

Your current physical condition ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription/over-the-counter or herbal supplement drugs? ☐ Yes ☐ No

Please list each one (*Name of med, dose, time taken, what it's taken for*):

_____

_____

_____

Are you taking any medications for Osteoporosis? Yes No

If so, what? _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Aspirin	Yes No	Erythromycin	Yes No	Penicillin	Yes No
Codeine	Yes No	Jewelry/Metals	Yes No	Tetracycline	Yes No
Sulfa	Yes No	Latex	Yes No	Other	Yes No

Please list any other drugs/materials that you are allergic to:

_____

_____

_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Abnormal Bleeding	Yes No	Herpes/Fever Blisters	Yes No
Alcohol / Drug Abuse	Yes No	High Blood Pressure	Yes No
Anemia	Yes No	HIV+ / AIDS	Yes No
Arthritis	Yes No	Hospitalized for any reason	Yes No
Artificial Bones, Joints, or Valves	Yes No	Kidney Problems	Yes No
Asthma	Yes No	Liver Disease	Yes No
Blood Transfusion	Yes No	Low Blood Pressure	Yes No
Cancer/Chemotherapy	Yes No	Lupus	Yes No
Colitis	Yes No	Mitral Valve Prolapse	Yes No
Congenital Heart Defect	Yes No	Pacemaker	Yes No
Diabetes	Yes No	Psychiatric Problems	Yes No
Difficulty Breathing	Yes No	Radiation Treatment	Yes No
Emphysema	Yes No	Rheumatic/ Scarlet Fever	Yes No
Epilepsy	Yes No	Seizures	Yes No
Fainting Spells	Yes No	Shingles	Yes No
Frequent Headaches	Yes No	Sickle Cell Disease	Yes No
Glaucoma	Yes No	Sinus Problems	Yes No
Hay Fever	Yes No	Stroke	Yes No
Heart Attack	Yes No	Thyroid Problems	Yes No
Heart Murmur	Yes No	Tuberculosis (TB)	Yes No
Heart Surgery	Yes No	Ulcers	Yes No
Hemophilia	Yes No	Venereal Disease	Yes No
Hepatitis	Yes No		

Please list any medical condition(s) that you have ever had:

_____

_____

MEDICAL HISTORY CONT.

Do you have trouble sleeping? ☐ Yes ☐ No

Do you feel tired or fatigued after sleep? ☐ Yes ☐ No

Do you feel like you get enough sleep at night? ☐ Yes ☐ No

Do you have a CPAP? ☐ Yes ☐ No

If so, do you wear it? ☐ Yes ☐ No

FOR WOMEN ONLY

Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week # _____

Are you nursing? ☐ Yes ☐ No

7 DISCLAIMER

MEDICAL & DENTAL

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical or dental status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

INSURANCE & FINANCIAL

Your dental insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. The responsibility of payment ultimately lies with each patient, not the insurance company. As a courtesy, we will file your claim on your behalf. I understand that I am required to pay my "Estimated Patient Portion" and any deductible due, to Canyon Echo Dental, LLC at the time of service. A statement will be sent to the patient for any balance which is not paid by the insurance company. I hereby authorize the release of any dental information that is needed to file my insurance. I have read the above statements and understand that I am responsible for payment in full after (45) days of my treatment, regardless of any delay in payment(s) by my insurance company. 15% annual interest is charged for any unpaid balance. A $15 fee is charged for nonpayment. There is a $50.00 processing charge for non-sufficient funds or returned checks. Records can be viewed at any time. There is a nominal charge for release or copies of records.

APPOINTMENTS & CANCELLATIONS

We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. We ask that if you must change an appointment, please give us at least 24 hours' notice. There is a $25 charge for broken or changed appointments less than 24 hours in advance. Repeated cancellations or missed appointments will result in loss of future appointment privileges and/or may be dismissed.

_____

Signature Date

_____

Print Name

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAS BEEN APPROVED.

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.