Sun Valley Smile Designs – John F. Calvert, D.D.S.

Welcome to our office. We look forward to serving you

Name:_____ **I prefer to be called:**_____ ☐ **Male** ☐ **Female**

Social Security#:_____ **Birthdate:**_____ **Age:**___ **Marital Status:** _____

Address:_____ **City:**_____ **Zip:**_____

Home Phone:_____ **Work Phone:** _____

Cell Phone:_____ **E-mail:**_____

How would you prefer to be contacted? _____

How did you hear about our office? _____

Employer:_____ **Occupation:**_____

Whom may we contact in the case of an emergency?_____ **Phone:** _____

Dental Insurance

Insurance Company: _____ **Phone #:** _____

Insurance Company Address: _____

City:_____ **State:**_____ **Zip:** _____

Are you the policy holder? ☐ **Yes** ☐ **No** **If no, what is your relation to the policy holder?** _____

Policy holder's name: _____ **Birthdate:**_____

Social Security #:_____ **Employer:** _____

Plan ID#:_____ **Group/Plan #:** _____

Do you have secondary insurance? ☐ **YES** ☐ **NO** **If yes, please let our administrative team know so that we may gather the necessary information.**

I authorize Dr. John Calvert to release any information acquired in the course of my examination or treatment to my insurance company or other care providers that I have been referred to or from whom I choose to receive care. I authorize that payment be made directly to Dr. John Calvert for services rendered. I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I understand and agree that (regardless of my insurance status), **I am ultimately responsible for the balance of my account.** I have read all the information on this sheet and have verified the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

_____ _____

Signature/Parent if minor **Date**

Medical Information

Your current health: ☐ GOOD ☐ FAIR ☐ POOR

Current Physician: _____

Please list any medications that you are currently taking: _____

_____

_____

_____

Women:

Are you pregnant? ☐ YES ☐ NO Due date: _____

Are you nursing? ☐ YES ☐ NO

Do you have or having ever been treated for any of the following diseases or conditions?

Y N	Abnormal Bleeding	Y N	Hepatitis
Y N	Alcohol/Drug Abuse	Y N	Herpes/Fever Blisters
Y N	Anemia	Y N	High Blood Pressure
Y N	Arthritis	Y N	HIV/AIDS
Y N	Artificial joints/bones/valves	Y N	Kidney Problems
Y N	Asthma	Y N	Liver Disease
Y N	Blood Transfusion	Y N	Low Blood Pressure
Y N	Cancer	Y N	Mitral Valve Prolapse
Y N	Congenital Heart Defect	Y N	Pacemaker
Y N	Diabetes	Y N	Psychiatric problems
Y N	Difficulty Sleeping	Y N	Radiation treatment
Y N	Difficulty Breathing	Y N	Rheumatic Fever
Y N	Emphysema	Y N	Scarlet Fever
Y N	Epilepsy	Y N	Seizures
Y N	Fainting spells	Y N	Shingles
Y N	Frequent Headaches	Y N	Sinus Trouble
Y N	Glaucoma	Y N	Sleep Apnea
Y N	Gum Disease	Y N	Stroke
Y N	Hay Fever	Y N	Thyroid Problems
Y N	Heart Attack	Y N	Tuberculosis (TB)
Y N	Heart Murmur	Y N	Ulcers
Y N	Heart Surgery	Y N	Venereal Disease (STD)
Y N	Hemophilia		

Do you smoke or chew tobacco? ☐ **YES** ☐ **NO**

Do you need to be pre-medicated for Mitral Valve Prolapse, Heart Murmur, or any kind of joint/bone/valve replacement?

☐ **YES** ☐ **NO**

Please circle any of the following which you are allergic to:

Aspirin	Codeine	Dental Anesthetics
Latex	Penicillin	Erythromycin
Codeine	Sulfa	Iodine

Please list any surgeries you may have had:

_____

_____

_____

Dental Information

Previous Dentist: _____

City/State: _____

Last Dental Visit: _____

Current Dental health: ☐ GOOD ☐ FAIR ☐ POOR

Are you happy with your smile? ☐ **Yes** ☐ **NO**

If there were anything you could change about your smile, what would it be?

_____

_____

Does food catch between your teeth?	**Y N**
Would you like for your teeth to be straighter?	**Y N**
Have you had orthodontic treatment?	**Y N**
Are you aware of clenching your teeth at night?	**Y N**
Do you ever have pain in your jaw or neck?	**Y N**
Do you have a bad odor/taste in your mouth?	**Y N**
Do your gums bleed when brushing/flossing?	**Y N**
Are your teeth sensitive to pressure?	**Y N**
Are your teeth sensitive to hot or cold?	**Y N**
Do you ever experience a burning tongue?	**Y N**
Does your jaw joint ever pop or click?	**Y N**
Have you ever been told that you snore?	**Y N**
Do you feel like you get a good night's sleep?	**Y N**

Do you have silver or discolored fillings or un-natural looking crowns or bridges that you wished looked different? **Y N** If yes, please explain:

___

_____

Please tell us about any other dental concerns that you may have or any information that you feel is important for us know: _____

_____

_____

Please tell us what you are looking for in a dental office, what is most important to you?

_____

_____

Please bring this completed form to your appointment or you may fax it to 208-726-0493.

Welcome to Sun Valley Smile Designs!

HIPAA Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information's used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Sun Valley Smile Designs

John F. Calvert, D.D.S.

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