DAMERON & TEAM

# Thank You for Selecting Dameron & Team

"Expect the Ordinary, Experience The Extraordinary"

**To help us meet all your dental needs, please fill out this form completely in ink.**
**If you have any questions or need assistance, please ask us and we will be happy to help.**

## Patient Information (Confidential)

Name _____ Birthdate _____

S.S. # _____ Email Address _____

Cell Phone _____ Home Phone _____ Office Phone _____

How should we remind you of appointments with our office? (Please Circle One) Phone: Home Work Cell Email Text

Other? _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College _____

City _____ State _____ ☐ Full Time ☐ Part Time

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

## Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____

Employer _____ Work Phone _____ S.S. # _____

## Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ S.S. # _____

Name of Employer _____ Work Phone _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

## Secondary Insurance

Name of Insured _____ Relationship to Patient _____

Birthdate _____ S.S. # _____

Name of Employer _____ Work Phone _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

# Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

| | Yes | No |
|---|---|---|
| 1. Are you under medical treatment now? | ☐ | ☐ |
| 2. Have you ever been hospitalized for any surgical operation or serious illness? If yes, please explain _____ | ☐ | ☐ |
| 3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____ | ☐ | ☐ |
| 4. Do you use tobacco? | ☐ | ☐ |
| 5. Do you use controlled substances? | ☐ | ☐ |
| 6. Are you wearing contact lenses? | ☐ | ☐ |

| 8. Are you allergic to or have you had any reactions to the following: | Yes | No |
|---|---|---|
| Local Anesthetics (e.g. novocain) | ☐ | ☐ |
| Penicillin or any other Antibiotics | ☐ | ☐ |
| Sulfa Drugs | ☐ | ☐ |
| Barbiturates | ☐ | ☐ |
| Sedatives | ☐ | ☐ |
| Iodine | ☐ | ☐ |
| Aspirin | ☐ | ☐ |
| Any Metals (e.g. nickel, mercury, etc.) | ☐ | ☐ |
| Latex Rubber | ☐ | ☐ |
| Other _____ | ☐ | ☐ |

7. Do you have or have you had any of the following?

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| High Blood Pressure | ☐ | ☐ | Heart Disease | ☐ | ☐ | Chest Pains | ☐ | ☐ |
| Heart Attack | ☐ | ☐ | Cardiac Pacemaker | ☐ | ☐ | Easily Winded | ☐ | ☐ |
| Rheumatic Fever | ☐ | ☐ | Heart Murmur | ☐ | ☐ | Stroke | ☐ | ☐ |
| Swollen Ankles | ☐ | ☐ | Angina | ☐ | ☐ | Hay Fever / Allergies | ☐ | ☐ |
| Fainting / Seizures | ☐ | ☐ | Frequently Tired | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Asthma | ☐ | ☐ | Anemia | ☐ | ☐ | Radiation Therapy | ☐ | ☐ |
| Low Blood Pressure | ☐ | ☐ | Emphysema | ☐ | ☐ | Glaucoma | ☐ | ☐ |
| Epilepsy / Convulsions | ☐ | ☐ | Cancer | ☐ | ☐ | Recent Weight Loss | ☐ | ☐ |
| Leukemia | ☐ | ☐ | Arthritis | ☐ | ☐ | Liver Disease | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Joint Replacement or Implant | ☐ | ☐ | Heart Trouble | ☐ | ☐ |
| Kidney Diseases | ☐ | ☐ | Hepatitis / Jaundice | ☐ | ☐ | Respiratory Problems | ☐ | ☐ |
| AIDS or HIV Infection | ☐ | ☐ | Sexually Transmitted Disease | ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ |
| Thyroid Problem | ☐ | ☐ | Stomach Troubles / Ulcers | ☐ | ☐ | Other _____ | ☐ | ☐ |
| Sleep Apnea | ☐ | ☐ | | | | | | |
| Snoring | ☐ | ☐ | | | | | | |

| 9. WOMEN ONLY: | Yes | No |
|---|---|---|
| a) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? | ☐ | ☐ |
| b) ARE YOU NURSING? | ☐ | ☐ |
| c) ARE YOU TAKING ORAL CONTRACEPTIVES? | ☐ | ☐ |

# Patient Dental History

Name of Previous Dentist _____

| | Yes | No |
|---|---|---|
| 1. Do your gums bleed while brushing or flossing? | ☐ | ☐ |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | ☐ | ☐ |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | ☐ | ☐ |
| 4. Do you feel pain to any of your teeth? | ☐ | ☐ |
| 5. Do you have any sores or lumps in or near your mouth? | ☐ | ☐ |
| 6. Have you had any head, neck or jaw injuries? | ☐ | ☐ |
| 7. Have you ever experienced any of the following problems in your jaw? | | |
| Clicking | ☐ | ☐ |
| Pain (joint, ear, side of face) | ☐ | ☐ |
| Difficulty in opening or closing | ☐ | ☐ |
| Difficulty in chewing | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| 8. Do you have frequent headaches? | ☐ | ☐ |
| 9. Do you clench or grind your teeth? | ☐ | ☐ |
| 10. Do you bite your lips or cheeks frequently? | ☐ | ☐ |
| 11. Have you ever had any difficult extractions in the past? | ☐ | ☐ |
| 12. Have you ever had any prolonged bleeding following extractions? | ☐ | ☐ |
| 13. Have you had any orthodontic treatment? | ☐ | ☐ |
| 14. Do you wear dentures or partials? If yes, date of placement _____ | ☐ | ☐ |
| 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? | ☐ | ☐ |
| 16. Do you like your smile? | ☐ | ☐ |
| 17. Are you interested in whitening | ☐ | ☐ |

# Authorization And Release

I certify that I have read and understand the above information to the best of myknowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and / or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ _____

Signature of patient (or parent if minor) (Date)

**Important Medical Alert**

A connection between **FOSAMAX** and other bisphosphonates, with a serious bone disease called Osteonecrosis of the Jaw (ONJ) has been found.

**BISPHOSPHATES** are commonly used in tablet form to prevent and treat osteoporosis in post-menopausal women, and older men. They are also used in the treatment of **PAGET'S DISEASE.** Stronger forms given orally or intravenously (I.V.) are commonly used in the management of advanced cancers including, but not limited to, lung cancer, breast cancer, prostate cancer, multiple myeloma and other metastatic cancers.

Have you **EVER** taken any of the following:
Oral Medications:

| | | |
|---|---|---|
| Y | N | Alendronate (Fosamax, Fosamax Plus) |
| Y | N | Clodronate (Bonefos,Ostac) |
| Y | N | Etidronate (Didronel) |
| Y | N | Ibandronate (Boniva) |
| Y | N | Pamidronate (Aredia) |
| Y | N | Risedronate (Actonel) |
| Y | N | Tiludronate (Skelid) |
| Y | N | Zoledronate (Zometa,Reclast) annual infustion |

Y N Have you ever been treated for cancer with chemo therapy in the past? This applies even if the treatments was many years prior

Intravenous I.V., cemo therapy

| | | |
|---|---|---|
| Y | N | Clondronate (Bonefos) |
| Y | N | Pamidranate (Aredia) |
| Y | N | Zoledronate (Zometa) |

If yes, When? _____

Prescribing Doctor Name & Phone#:
_____
_____

Signature _____

Print Name _____Date_____

DAMERON & TEAM

BRETT A.
DAMERON, D.D.S.

Member of: American Dental Association
Academy of General Dentistry
American Academy of Cosmetic Dentistry

FAMILY DENTISTRY
*"Committed to Excellence"*

12320 North 32nd Street, Suite 1
Phoenix, AZ 85032
Phone (602) 992-1384
Fax (602) 992-6104
drdameron@drdameron.com
www.drdameron.com

# PRIVACY PRACTICES ACKNOWLEDGEMENT

**Privacy Notice Amendment September 2013**

I have had the opportunity to read the Patient Privacy Notice for this practice. I understand that I may ask for a copy to take with me at any time, and that an appointed person is available to answer any questions that I may have now, or in the future, regarding the use on my Personal Health Information.

_____
Patient Signature

_____
Date

_____
Practice Witness

_____
Date

Dameron & Team

12320 N 32nd St # 1

Phoenix, AZ 85032

# Disclosure Agreement

**I _____** give permission to Dr. Dameron & Team to
Print Name
discuss my treatment and/or billing issues with the following people.

1. _____
2. _____
3. _____
4. _____
5. _____

Signature _____

Date _____

# OFFICE USE ONLY

DAMERON & TEAM

## Sleep Apnea Evaluation

(For Office Use)

| | | | | |
|---|---|---|---|---|
| 1) Large "Scalloped" Tongue: | Yes | No | | |
| 2) Bruxism: | Yes | No | | |
| 3) Class II Molar >3mm: | Yes | No | | |
| 4) Dentin Exposure: | Yes | No | | |
| 5) Class V Erosion: | Yes | No | | |
| 6) High Arched Palate: | Yes | No | | |
| 7) Tapered Jaws: | Yes | No | | |
| 8) Xerostemia: | Yes | No | | |
| 9) Tonsil Classification: | I | II | III | IV |
| 10) Mallampati Classification: | I | II | III | IV |

## Medical Conditions

| | | |
|---|---|---|
| 1) High BP: | Yes | No |
| 2) Stroke/Heart Conditions: | Yes | No |
| 3) GERD: | Yes | No |
| 4) Anti-depressants: | Yes | No |
| 5) Obesity: | Yes | No |
| 6) Daytime Sleepiness: | Yes | No |
| 7) Diabetes: | Yes | No |
| 8) Cancer: | Yes | No |

Additional: _____

DAMERON & TEAM

Name_____ DOB_____ Date_____

This questionnaire was developed based upon the published findings of the American Academy of Sleep Medicine (AASM). The purpose of this questionnaire is to aid Dr. Dameron in identifying possible symptoms of a sleep disorder and is not meant to be used as a substitute for any diagnostic procedure.

| | | |
|---|---|---|
| Have you ever been told you stop breathing while you're sleeping? | 8 | Yes/No |
| Have you ever fallen asleep or nodded off while driving? | 6 | Yes/No |
| Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing? | 6 | Yes/No |
| Do you feel excessively sleepy during the day? | 4 | Yes/No |
| Do you snore, or have you ever been told that you snore? | 4 | Yes/No |
| Have you had weight gain or found it difficult to lose? | 2 | Yes/No |
| Have you taken medication for, or been diagnosed with high blood pressure? | 2 | Yes/No |
| Do you kick or jerk your legs while sleeping? | 3 | Yes/No |
| Do you feel burning, tingling or crawling sensations in your legs when you wake up? | 3 | Yes /No |
| Do you wake up with headaches during the night or in the morning? | 3 | Yes /No |
| Do you have trouble falling asleep? | 4 | Yes/No |
| Do you have trouble staying asleep once you fall asleep? | 4 | Yes/No |
| Have you been diagnosed with a sleep disorder? | | Yes/No |
| Are you currently using a CPAP machine? | | Yes/No |
| If yes, are you wearing your CPAP every night? | | Yes/No |

Total:_____

For Clinical Use Only

| Low | Moderate | High | Severe |
|---|---|---|---|
| 0-7 | 8-11 | 12-15 | 16+ |

Our Doctors & staff are very concerned about the cost of your dental needs & would like to address some current issues related to the cost of dental services in this office. Considerable care has been taken in setting up our fee schedule. We would like to assure you that the charges accurately reflect the skill & expertise required as well as quality of materials used to provide the best service for you. Our fees are comparable with fees of other dentists in the area that provide similar quality care.

If any insurance company indicates that our fees are above the "Usual & Customary", please understand that most dentist fees are above the rate which insurance companies choose to pay. We cannot and do not allow insurance companies to set or dictate fees or service we provide our patients. Our policy requires payment at time of service. As always, we do accept Visa, MasterCard, American Express and Discover.

If you have insurance you must pay your estimated portion at the time of service. As a courtesy we will file the claim with your insurance carrier. However, our agreement for payment is with you and NOT your insurance company. Payment to our office is neither contingent nor dependent upon your insurance.

There is a $25.00 service charge for all returned checks. There will be interest charged if your account becomes delinquent beyond 30 days. You understand that if you default on your payments, an outside collection agency will be used. You understand that you will be responsible for the collection fees of 45% of the outstanding balance. You also understand should suit be brought against you, you will be responsible for court costs and attorney fees.

I have read and understand my financial responsibilities under this policy.

_____ _____

Patient/Responsible Party Signature Date