CANEPA DENTISTRY

WELCOME TO OUR PRACTICE

We would like to get to know you better. Please take a minute to fill out this questionnaire so we may better serve you.

1. How did you choose our office?

   ☐ Family ☐ Internet:_____ ☐ Advertisement: _____

   ☐ Individual (If so, who? _____) ☐ Other: _____

2. Let's get acquainted. Tell us about yourself…

   Hobbies & interests _____

   Family/Kids_____

3. Today's dentistry allows us to enhance your smile in multiple ways. How would you like your teeth to look?

   ☐ Straighter or white

   ☐ Less gaps or more

   ☐ Longer or shorter

   ☐ Replace missing teeth

   ☐ Replace uncomfortable fillings or partials

   ☐ Other: _____

   _____

4. Are there any special occasions coming up? If so, when would you like to begin?

_____

Patient Information and Medical History

Patient Name: _____ Date: _____
Last First M.I. Preferred Name

Birthdate: _____ Social Security Number: _____

Gender: _____ Marital Status: _____ Referred by: _____

Phone (Home): _____ (Cell): _____

Address: _____
Street

_____
City State Zip Code

E-mail: _____

Employer: _____ Occupation: _____

Primary Care Physician: _____ Phone: _____

Preferred Pharmacy & Phone Number: _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain, and how long ago:

_____

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Local Anesthetics ☐ Acrylics ☐ Metals (nickel, other: _____)
☐ Opioids ☐ Sulfa drugs ☐ Barbiturates ☐ Latex (Rubber)
☐ Other: _____

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

☐ AIDS or HIV
☐ Alzheimers
☐ Anemia
☐ Arthritis/Gout
☐ Artificial Joints
☐ Artificial Heart Valve
☐ Asthma
☐ Blood Disease
☐ Blood Transfusion
☐ Bruises Easily
☐ Cancer
☐ Chemotherapy
☐ Heart Defect (including a damaged, repaired, or unreparied valve, cyanotic defect, or congenital disease)
☐ Cortisone Medicine
☐ Diabetes
☐ Drug Addiction
☐ Emphysema
☐ Epilepsy/Seizures
☐ Dialysis
☐ Dizziness
☐ Excessive Thirst
☐ Headaches
☐ Glaucoma
☐ Hay Fever
☐ Heart Murmur
☐ Heart Disease
☐ Hemophilia
☐ Hepatitis A, B, or C
☐ High Blood Pressure
☐ High Cholesterol
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Low Blood Pressure
☐ Lupus
☐ Lung Disease
☐ Mitral Valve Defect
☐ Organ Transplant
☐ Osteoporosis
☐ Pacemaker
☐ Pain in Jaw Joints
☐ Thyroid Disease
☐ Psychiatric Condition
☐ Radiation Treatment
☐ Rheumatic Fever
☐ Sickle Cell Disease
☐ Sinus Trouble
☐ Spina Bifida
☐ Stomach/Intestinal Issues
☐ TIA/Stroke
☐ Swelling of Limbs
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors/Growths
☐ Ulcers
☐ Other
_____
_____
_____
_____
_____
_____
_____

Do you premedicate?

☐ Yes ☐ No
For: _____

Medications (please list)
_____
_____
_____
_____
_____
_____
_____
_____
_____

☐ Tobacco (type, how long)
_____

☐ Alcohol (type, how long)
_____

☐ Illicit: _____
_____

If yes to any conditions above, please explain:

_____

_____

CANEPA DENTISTRY

Patient Information and Medical History

Have you ever had any serious illness not listed above? ☐ Yes ☐ No

Comments: _____

_____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No

If yes, please explain: _____

Are you or have you taken oral bisphosphonates or IV medication for osteoporosis or Paget's disease? Examples include: denosumab (Prolia), alendronate (Fosamax), ibandronate (Boniva), risedronate (Actonel), zolendronate (Reclast). ☐ Yes ☐ No

Are you taking any blood thinners? Examples include rivaroxaban (Xarelto), coumadin (Warfarin), dabigatran (Pradaxa), clopidogrel (Plavix), apixaban (Eliquis) ☐ Yes ☐ No

Women: Are you taking oral contraceptives? ☐ Yes ☐ No Are you currently pregnant? ☐ Yes ☐ No If yes, due date: _____. Are you nursing? ☐ Yes ☐ No

Dental Health History

Date of Last Dental Visit:_____ Last Cleaning:_____ X-Rays:_____

Have you ever had any of the following? Check all that apply:

☐ Hot or cold sensitivity ☐ Bleeding gums ☐ Clenching or grinding ☐ Pain (Joint, ear, or side of face
☐ Orthodontic treatment ☐ Gum treatment ☐ Strange or new bumps in the head and neck region
☐ Dry mouth ☐ Other: _____

If yes, please explain: _____

_____

In case of an emergency, contact: _____

Phone: _____

Relationship: _____

I affirm the above information has been answered correctly. I will not hold Canepa Dentistry or its personnel responsible for any complication arising from errors or omissions in the information provided.

Signature (Patient, parent, or guardian) _____ Date: _____

Appointment Agreement

Our practice is dedicated to your quality care and is pleased to reserve this time for you. If you find you cannot keep your appointment, **we require a minimum 48 hour notification**. This permits another patient to receive dental care in your absence. Without notice, a failed appointment fee of $50 will be charged. If multiple appointments are cancelled without proper notice, future appointments may require a deposit. By signing below, you understand our cancellation policy and will make every attempt to give us proper notification. Thank you for your cooperation.

Signature: _____ Date: _____

Financial Policy

Payment is expected at the time of visit. If payment arrangements are necessary, our Office Coordinator will be happy to work with you prior to beginning treatment. For your convenience, we do accept most Major credit cards, cash or checks. **Returned checks are subject to a $35.00 NSF charge**. If you have dental insurance, it is our policy to file the claim as a courtesy to you. If your insurance company does not remit payment within 30 (thirty) days, the balance will be due from you. Please realize that your insurance is a contract between you and your insurance carrier and not all services / procedures are covered by insurance companies. A written treatment plan will be given to you prior to services being performed and should any changes occur during the course of treatment you will be notified. All insurance estimates are based on information your carrier has given us. Our team prides itself on helping our patients maximize their benefits and are always available to answer your questions. We encourage you to read your policy and if further clarification is needed, talk to your employer and/or insurance carrier.

Signature: _____ Date: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By either printing and signing this form, or submitting this form electronically, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available here. We encourage you to read it carefully and completely before signing this Consent.

Right to Revoke: You have the right to revoke this Consent at any time by sending written notice of your revocation to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we have taken in reliance on this Consent before we received your revocation. Also, we may decline to treat you or to continue treating you, if you revoke this Consent.

I, _____(printed) have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature _____ **Date**_____

If you would like to authorize Dr. Canepa DMD to discuss personal treatment and finances with any individual (s), please list the person (s) name and relationship:

1._____ phone number _____

2._____ phone number_____

3._____ phone number_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative Name: _____

Relationship to Patient: _____

IF REQUESTED, YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

General Consent To Dental Treatment

I authorize Dr. Colt Canepa, and such personnel as may be necessary to perform the procedures in the attached treatment plan, in the process of maintaining the dental health of myself, my minor, or other individual(s) for which I have responsibility. This includes the arrangement and/or administration of nitrous oxide, analgesics, or other pharmaceutical agent(s).

While standard and often predictable, dental treatment is surgical in nature, and certain risks apply:

1. Treatment Plan: I understand treatment plans may change as care progresses. It may be necessary to modify or add procedures based on conditions encountered.

2. Examinations and radiographs: I understand that additional radiographs may be necessary throughout the course care, as well as to satisfy the needs of future examinations, diagnoses, and treatment.

3. Local and regional anesthesia: I understand the administration of anesthetics may cause adverse reactions, including, but not limited to bruising, hematoma, cardiac stimulation, infection, soreness, and very rarely, temporary or permanent sensory damage or numbness of the innervated area. Very rarely, needles break, and may require surgical retrieval. In some cases, infection or cardiac stimulation can be fatal.

4. Temporomandibular joint dysfunction (TMD): After lengthy appointments, jaw muscles may become sore or tender. Holding one's mouth open can exacerbate or lead to a TMJ disorder. Should the need for treatment arise, referral to a specialist may be necessary.

5. Pulpal sensitivity: As part of dental treatment, including restorations of any type or hygiene procedures, teeth may become sensitive or even painful. If reversible, this condition usually resolves within 6-8 weeks. If sensitivity remains, additional procedures may be necessary, such as endodontic therapy, and/or referral to a specialist, of which I will be financially responsible.

6. Dental restorations (fillings, inlays, onlays, crowns, bridges, veneers): I understand that dental restorations of any kind are not altered by whitening products used in the future, and any changes in the color of natural teeth must be made prior to restorative treatment. I recognize that sometimes it is not possible to replicate the color of natural teeth entirely with restorative materials. I further understand that I may be wearing temporary restorations, which may come out, and require recementation to avoid tooth movement until the permanent restoration is delivered. I realize the final opportunity to make changes to crowns, bridges, veneers, or other lab-made restorations is prior to long-term cementation. It is my responsibility to return for delivery of the restoration(s) within one month of preparation, as delays may result in the need for the procedure to be repeated, incurring additional fees. Like natural teeth, dental restorations of any kind must be kept clean with proper oral hygiene and periodic professional cleanings, otherwise decay or periodontal disease may develop, compromising the prognosis of the tooth or teeth.

Initials _____

Turn Over

General Consent To Dental Treatment

7. Periodontal disease: I understand that periodontal disease is a serious condition that causes inflammation, as well as the loss of supporting bone and soft-tissues around teeth. Without intervention, this process may ultimately result in tooth loss. Treatment for periodontal disease can involve scaling and root planing, as well as other periodontal procedures. Following periodontal treatment, air spaces or "black triangles" may be present between teeth resulting in altered esthetics, in addition to food entrapment.

8. Longevity of dental materials: Nothing in dentistry lasts forever. Generally speaking, tooth-colored restorations do not last as long as metal restorations, and more treatment will be needed throughout a lifetime if tooth-colored restorations are elected. A predictable timeframe for a tooth-colored material to last is 10-20 years. Metal has the potential to last 20-40 years. For a person age 18 receiving tooth-colored restorations, this may result in a number of teeth needing crowns, root canals, extractions, and potential replacement with implants by age 40-60, requiring large amounts of treatment and financial expenditures. While not warranties, estimated performance times include:
    - Direct tooth-colored composites: Posterior teeth 5-15 years; anterior teeth 8-20 years
    - Ceramic tooth-colored indirect restorations (inlays, onlays, crowns): 10-20 years
    - Direct or indirect metal restorations (fillings, inlays, onlays, crowns): 20-40 years

9. Damage to teeth or adjacent tissues: It is possible for the tongue, cheek, adjacent teeth, or other intraoral tissues to be abraded during dental procedures. In some cases, sutures or additional treatment may be necessary.

10. Ingestion of foreign bodies: I understand that as part of dental treatment, small items such as crowns, 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.

The benefits of dental treatment include the ability to diagnose and treat active disease, damage, or other conditions affecting the teeth, periodontium, or other oral hard and soft tissues.

Alternatives to care include the option of no treatment, alternative treatment plans, secondary opinion, or specialty referral/consultation, including orthodontics and periodontics.

I have fully disclosed my medical history, as well as any prescription or non-prescription drugs I am currently taking or have taken in the past. This includes bishosphonates or other osteoporosis medications, such as Fosamax, Boniva, Prolia, Reclast, Didronel, Aredia, or Actonel.

The details of treatment, including the potential risks, benefits, and alternatives to care have been explained to me in ways I understand. I have been given the opportunity to ask questions, understand the nature of the planned procedures, and agree to proceed.

Patient Name: _____

Signature: _____ Date: _____

(Patient, legal guardian or authorized agent of patient)

ATTENTION PATIENTS WITH INSURANCE

IF YOU FAIL TO PROVIDE CORRECT OR UPDATED INSURANCE INFORMATION **1 WEEK** PRIOR TO YOUR APPOINTMENT, YOU WILL BE RESPONSIBLE FOR THE FULL AMOUNT OF YOUR BILL, OR YOUR APPOINTMENT WILL BE CANCELLED. PLEASE MAKE SURE TO UPDATE US WITH **ANY** CHANGES TO YOUR INSURANCE.

WHILE CANEPA DENTISTRY WILL MAKE EFFORTS TO SUBMIT INSURANCE CLAIMS ON BEHALF OF THE PATIENT, COLLECT PAYMENT, AND OFFER APPEALS FOR CLAIMS, IF A CLAIM IS DENIED OR DOWNGRADED FOR ANY REASON, THE PATIENT WILL BE RESPONSIBLE FOR THE REMAINING BALANCE.

An example is if you receive a filling or crown that is tooth-colored. Your dental insurance may claim the tooth is fixable with a metal, silver-colored option, and they will only pay for the amount that covers this type of restoration. In such a case, the patient will be responsible for the financial difference, which may amount to several hundred dollars.

I have read and agree to the above policy.

Name: _____

Signature: _____ Date: _____

(Patient, legal guardian or authorized agent of patient)

CANEPA DENTISTRY