AGAVE DENTAL

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

About You

Name _____
(First) (MI) (Last)

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. I prefer to be called: _____

Birthdate: _____ SS#: _____

Home Address: _____

City: _____ State: _____ Zip: _____

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Cell: _____ Home Phone: _____

Work Phone: _____ Email: _____

Employer: _____ Occupation: _____

What is your preferred method of contact? Please circle: Phone Text Email

Who may we thank for referring you _____

Other family members seen by us: _____

Responsible Party's Information

His/Her Name: _____
(First) (MI) (Last)

Birthdate: _____ SS#: _____

Employer: _____ Occupation: _____

Cell: _____ Home Phone: _____

Work Phone: _____ Email: _____

Emergency Contact

In the event of an emergency, who would you like us to contact?

Name: _____

Relationship: _____

Cell: _____ Home Phone: _____

Email: _____

Dental Insurance

Primary Dental Insurance

Name of Insurance Co.: _____

Address: _____

_____

Phone #: _____

Group #: _____

Policy Holder Name: _____

Relation to policy holder. Please circle: Self Spouse Child Other

Insured's Birthdate: _____ Member ID# or SSN: _____

Insured's Employer: _____

Secondary Dental Insurance

Name of Insurance Co.: _____

Address: _____

_____

Phone #: _____

Group #: _____

Policy Holder Name: _____

Relation to policy holder. Please circle: Self Spouse Child Other

Insured's Birthdate: _____ Member ID# or SSN: _____

Insured's Employer: _____

Pharmacy Information

Pharmacy Name: _____

Pharmacy Number: _____

AGAVE DENTAL

Dental History

What are your main dental concerns today? _____

Are you currently in pain or discomfort with your teeth and/or gums? ❑ Yes ❑ No _____

How would you describe the condition of your teeth and gums? ❑ Excellent ❑ Fair ❑ Poor

Last Dental Visit Date: Previous Dentist:

Do you have headaches? ❑ Yes ❑ No If YES, how often?

Have you had orthodontics? ❑ Yes ❑ No If YES, at what age?

AGAVE DENTAL

Questionnaire

Gums

❑ Y ❑ N Do your gums ever bleed?

❑ Y ❑ N Have you ever had a "deep cleaning"?

❑ Y ❑ N Have you ever been told you have gum disease?

Joints

❑ Y ❑ N Do you grind or clench your teeth?

❑ Y ❑ N Have you ever had pain/discomfort in your jaw joint? Lock jaw?

❑ Y ❑ N Do you have muscle pain in your face/neck?

❑ Y ❑ N Do you snore or have you been told you do?

❑ Y ❑ N Do you sleep well? How many hours? _____

Esthetics

❑ Y ❑ N Would you like to have whiter teeth?

❑ Y ❑ N Would you like your teeth to be straighter?

❑ Y ❑ N Are you unhappy with any silver or discolored fillings?

❑ Y ❑ N Do you have crowns or bridges which are unattractive or unnatural looking?

❑ Y ❑ N Do you sometimes feel uncomfortable with the appearance of your smile?

❑ Y ❑ N Are you afraid or anxious to visit the dentist?

Do you have any additional concerns that you would like to discuss with the doctor? _____

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

I authorize any photographs or slides to be taken of me during treatment at Agave Dental for educational purposes, laboratory fabrication, or internal office use. I fully understand that other dentists, team members, and other patients may view these photos for educational and / or treatment purposes.

Signature: **Date:**

AGAVE DENTAL

Medical History

Patient Name: _____ DOB: ____/____/____

Are you currently under the care of a physician ❑ Yes ❑ No? If YES, please provide the following: _____

Physician's Name: _____ Physician's Phone #: _____

Describe your current physical health: ❑ Excellent ❑ Fair ❑ Poor

Do you Smoke or use Smokeless Tobacco? ❑ Yes ❑ No Please circle any that apply: Cigarettes Cigars Vape Marijuana Chew Other_____

FOR WOMEN: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No If yes, # of weeks _____ Are you nursing? ❑ Yes ❑ No

❑ Y ❑ N Have you ever taken Boniva or Alendronate (Fosamax)? _____

Do you now or have you ever had any of the following medical conditions?

❑ Y ❑ N Blood Conditions (Check all that apply)
- ❑ Anemia
- ❑ Bruise Easily
- ❑ Hemophilia

❑ Y ❑ N Bone / Joint (Check all that apply)
- ❑ Artificial Joint: _____
- ❑ Arthritis - type: _____
- ❑ Pain in the Jaw
- ❑ Osteoporosis / Osteopenia

❑ Y ❑ N Cancer (Check all that apply)
- ❑ Leukemia
- ❑ Radiation Treatment
- ❑ Chemotherapy

❑ Y ❑ N Heart Conditions (Check all that apply)
- ❑ Angina / Chest Pain
- ❑ Artificial Heart Valve
- ❑ Heart Attack
- ❑ Heart Disease / Defect
- ❑ Heart Failure

Heart Conditions Continued
- ❑ Heart Pacemaker
- ❑ Heart Surgery
- ❑ High Blood Pressure
- ❑ Irregular Heart Beat
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Stroke

❑ Y ❑ N Lung Conditions (Check all that apply)
- ❑ Breathing Problems
- ❑ Tuberculosis (TB)
- ❑ Asthma - type: _____
- ❑ Emphysema / COPD

❑ Y ❑ N Stomach / Intestinal Condition (Check all that apply)
- ❑ Ulcers
- ❑ Liver Disease
- ❑ Hepatitis - type: _____
- ❑ Kidney Problems

❑ Y ❑ N AIDS / HIV Positive
❑ Y ❑ N Allergies (Seasonal)
❑ Y ❑ N Autoimmune Disease: _____
❑ Y ❑ N Cold Sores / Fever Blisters
❑ Y ❑ N Depression
❑ Y ❑ N Diabetes - type: _____
❑ Y ❑ N Drug Use / Addiction
❑ Y ❑ N Epilepsy / Seizures
❑ Y ❑ N Fainting / Dizziness
❑ Y ❑ N Hypoglycemia
❑ Y ❑ N Nervousness
❑ Y ❑ N Rheumatic Fever
❑ Y ❑ N Sinus Problems
❑ Y ❑ N Thyroid Disease
❑ Y ❑ N Other: _____

Are you allergic to any of the following?

❑ Y ❑ N Aspirin
❑ Y ❑ N Codeine
❑ Y ❑ N Dental Anesthetics
❑ Y ❑ N Erythromycin
❑ Y ❑ N Jewelry / Metals
❑ Y ❑ N Latex
❑ Y ❑ N Penicillin
❑ Y ❑ N Tetracycline
❑ Y ❑ N Other: _____

❑ Y ❑ N Have you ever been hospitalized or had any major surgeries? Please specify:_____

Please list any over-the-counter and prescription medications that you are currently taking, including supplements.

Medication / mg	Dosage	Reason for Taking Medication

Patient Signature: _____ **Date:** _____

AGAVE DENTAL

EPWORTH SLEEPINESS SCALE/ ORAL FACIAL PAIN EVALUATION

PATIENT NAME_____ DOB _____ MEDICAL INS. _____DATE _____

ADDRESS _____ PHONE _____ EMAIL _____

Using the scale provided, please answer how likely you are to doze off or fall asleep in the following situations, if you allowed yourself to do so:

0 = Would never doze 1 = Slight Chance of Dozing 2 = Moderate Chance of Dozing 3 = High Chance of Dozing

ACTIVITY	SCORE
SITTING AND READING	_____
WATCHING TV	_____
SITTING, INACTIVE IN A PUBLIC PLACE (THEATER, MEETING, ETC)	_____
AS A PASSENGER IN A CAR FOR AN HOUR WITHOUT A BREAK	_____
LYING DOWN TO REST IN THE AFTERNOON WHEN CIRCUMSTANCES PERMIT	_____
SITTING AND TALKING TO SOMEONE	_____
SITTING QUIETLY AFTER LUNCH WITHOUT ALCOHOL	_____
IN A CAR, WHILE STOPPED FOR A FEW MINUTES IN TRAFFIC	_____
TOTAL	_____

Please mark if you suffer from or have been told you have any of the following:

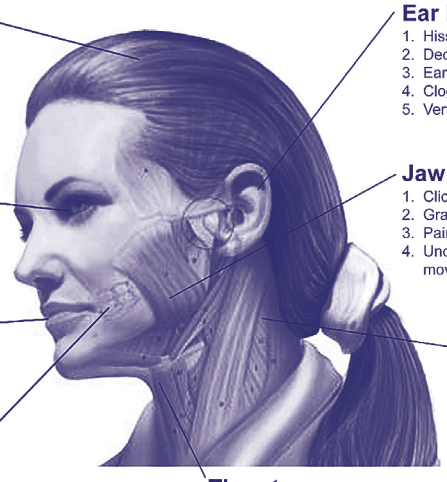
_____ Loud Snoring
_____ Diabetes
_____ Depression
_____ Acid Reflux
_____ CPAP Intolerance
_____ Morning Headaches
_____ Frequent Nighttime Urination
_____ Told you stop breathing during sleep
_____ Obesity/ Weight Gain
_____ Lack of Energy
_____ Wake up Gasping
_____ Decreased Concentration
_____ Daytime Tiredness
_____ COPD
_____ Thyroid Dysfunction
_____ Never Feeling Rested
_____ High Blood Pressure
_____ Drowsy Driving

For Women Only:
_____ Pregnant
_____ Postmenopausal
_____ Premenopausal
_____ Polycystic Ovary Syndrome
_____ Hysterectomy

SIGNS & SYMPTOMS OF ORAL/FACIAL PAIN (Please circle all symptoms that apply)

Check Below:

- ☐ HEADACHES
- ☐ JAW JOINT PAIN
- ☐ JAW JOINT NOISE OR CLICKING
- ☐ LIMITED MOUTH OPENING
- ☐ EAR CONGESTION
- ☐ DIZZINESS
- ☐ RINGING IN EARS
- ☐ DIFFICULTY SWALLOWING
- ☐ LOOSE TEETH
- ☐ CLENCHING OR GRINDING
- ☐ FACIAL PAIN
- ☐ SENSITIVE TEETH
- ☐ CHEWING DIFFICULTIES
- ☐ NECK PAIN
- ☐ POSTURAL PROBLEMS
- ☐ TINGLING IN FINGERTIPS
- ☐ HOT & COLD TEETH SENSITIVITY
- ☐ NERVOUSNESS OR INSOMNIA



Head Pain, Headache
1. Forehead
2. Temples
3. "Migraine" type
4. Sinus type
5. Shooting pain up back of head
6. Hair and/or scalp painful to touch

Ear Problems
1. Hissing, buzzing or ringing
2. Decreased hearing
3. Ear pain, ear ache, no infection
4. Clogged, "itchy" ears
5. Vertigo, dizziness

Eyes
1. Pain behind eyes
2. Bloodshot eyes
3. May bulge out
4. Sensitive to sunlight

Jaw Problems
1. Clicking, popping jaw joints
2. Grating sounds
3. Pain in cheek muscles
4. Uncontrollable jaw and/or tongue movements

Mouth
1. Discomfort
2. Limited opening of mouth
3. Inability to open smoothly
4. Jaw deviates to one side when opening
5. Locks shut or open
6. Can't find bite

Neck Problems
1. Lack of mobility, stiffness
2. Neck pain
3. Tired, sore muscles
4. Shoulder aches and backaches
5. Arm and finger numbness and/or pain

Teeth
1. Clenching, grinding at night
2. Looseness and soreness of back teeth

Throat
1. Swallowing difficulties
2. Laryngitis
3. Sore throat with no infection
4. Voice irregularities or changes
5. Frequent coughing or constant clearing of throat
6. Feeling of foreign object in throat constantly

☐ Patient scheduled an appt on _____ ☐ Patient wants to be called ☐ Does not want to be contacted about Epworth/OFP Results

AGAVE DENTAL
Smile Esthetics and Wellness

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

If the patient is less than 18 years of age, a parent or legal guardian must sign.

I, _____, have received a copy of this office's Notice of Privacy Practices
(Please Print Patient's Name)

_____
(Signature of Patient or Parent/Legal Guardian)

_____
(Date)

For Patients who need pre-medication only:
I am authorizing this office to call me and remind me to take my pre-medication before my dental appointment. They may leave a message for me regarding this information at any number that I have supplied to them. They may leave a message on any answering machine, voice mailbox or with whomever answers the telephone. I also authorize this office to remind me of my pre-medication on any postcard reminders that the office will mail to me.

_____
(Signature of Patient or Parent/Legal Guardian)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Patient reviewed Privacy Practices, but elected not to take a copy home
- ❑ Other (Please Specify)

Employee signature: _____ Date: _____

_____

_____

AGAVE DENTAL
Smile Esthetics and Wellness

At Agave Dental we are committed to providing you with the best possible care. We want you to have a **great** dental experience! Our professional relationship is based on mutual trust and understanding. If, at any time, you have any questions or concerns, we are here and happy to help. We feel that open communication is the best way to avoid any confusion or misunderstanding.

*****Please read (and initial) each of the following statements regarding your insurance and our office financial policy.**

Insurance:

_____ **We must emphasize, as dental care providers, that your insurance policy is a contract between you, your employer and the insurance company. We are not a party to that contract and we do not determine if services are covered or non-covered.** We will bill your insurance company as a courtesy to you- please understand that all charges are your responsibility from the day services are rendered- regardless of any pending insurance. If we are in network with your insurance company that means we are required to use their fee schedule for any covered procedures.

_____ We try to estimate your co-insurance as closely as possible with the information that we have. After the insurance company processes your claim there may be a balance or a credit. We will send you a statement if there is a balance due or return your credit to the original form of payment used.

_____ If your insurance company has not processed your claim within 60 days, you may be billed for the remaining amount due and then be reimbursed if, and/or when, the insurance company makes their final determination of your claim.

Forms of Payment:

_____ We take cash, check, Visa, Master Card, Discover, American Express and Care Credit. (We also have an in-office payment plan option – please ask anyone at the front desk for more details).

_____ All co-payments are due at the time services are rendered. Any payment plan/arrangements must be made prior to having services performed.

_____ Returned checks are subject to an additional $40.00 fee

Missed Appointments:

_____ We have reserved time in the schedule specifically for you. We do require 48 hours notice to change any appointment you have reserved. If less than 48 hours notice is given - there will be a charge in the amount of $50.00 per hour. Please help us provide you with the best service by keeping your reserved appointment times.

I understand and agree to the above Financial Policy.

Signature of patient/guardian: _____ Date: _____