DR. JEFFREY C. DERICKSON, D.D.S. P.L.L.C. 762 N. COUNTRY CLUB RD. TUCSON, AZ. 85716 Ph: (520) 327-5993

WELCOME TO OUR OFFICE

TODAY'S DATE:________________________

PATIENT INFORMATION:

NAME:____BIRTH DATE:________________________ SS#:______________________________
LAST FIRST MI

HOME ADDRESS:____
STREET CITY STATE ZIP

HOME PHONE#:______________________ CELL #:______________________ WORK#:______________________ E-MAIL:________________________

EMPLOYER:_____________________________ OCCUPATION:_____________________________ REFERRED BY:______________________________

EMERGENCY
CONTACT:____
NAME HOME # ALTERNATE #

SPOUSE INFORMATION:

SPOUSE'S NAME:____ OCCUPATION:____

EMPLOYER:____ WORK#:______________________________ EXT:______________________

ACCOUNT INFORMATION:

PRIMARY DENTAL INSURANCE COMPANY:____

GROUP#:_________________

CLAIMS ADDRESS:____ TOLL FREE#:____________________________
STREET CITY STATE ZIP

PRIMARY SUBSCRIBER INFORMATION:

NAME:____BIRTH DATE:________________________ SS#:______________________________
LAST FIRST MI

MEMBER ID#:____ EMPLOYER:____

OCCUPATION:_______________________________________ WORK#:____________________________ EXT:_______ HOME#:______________________

HOME ADDRESS:____
STREET CITY STATE ZIP

SECONDARY DENTAL INSURANCE COMPANY:____

GROUP#:_________________

CLAIMS ADDRESS:____ TOLL FREE#:____________________________
STREET CITY STATE ZIP

SECONDARY SUBSCRIBER INFORMATION:

NAME:____BIRTH DATE:_________________________ SS#:______________________________
LAST FIRST MI

MEMBER ID#:____ EMPLOYER:____

OCCUPATION:_______________________________________ WORK#:____________________________ EXT:_________ HOME#:____________________

HOME ADDRESS:____
STREET CITY STATE ZIP

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT:

SELF ☐ SPOUSE ☐ MOM ☐ DAD ☐ OTHER ☐

NAME:____BIRTH DATE:________________________ SS#:_____________________________
LAST FIRST MI

HOME ADDRESS:____
STREET CITY STATE ZIP

HOME PHONE#:___________________________ CELL#:_____________________________ WORK#:________________________ EXT:___________

EMPLOYER:____ OCCUPATION:____

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HEALTH HISTORY

1. Do you have pain from any area of your mouth? YES ☐ NO ☐ If yes, where?____
2. Are you in good health? YES ☐ NO ☐
3. Your last physical examination was on ____
4. Are you now under the care of a physician? YES ☐ NO ☐
   a. Physician's name and phone number:____
5. Have you been hospitalized or had a serious illness within the past 5 years? YES ☐ NO ☐
   a. If yes, explain:____
6. Are you now taking any medication drugs or pills? YES ☐ NO ☐
   a. If yes, please list those drugs/reasons:____
7. Are you allergic or have you reacted to any of the following medications (please check if yes)

Nitrous Oxide ☐	Nembutal/Seconal ☐	Penicillin ☐	Aspirin ☐	Erythromycin ☐	Percodan ☐
Scopolamine ☐	Tetracycline ☐	Darvon ☐	Codeine ☐	Demerol ☐	Valium ☐
Sleeping Pills ☐	Novacaine or Xylocaine ☐	Other Antibiotics:____________________			
Metals:____________________		Other:____________________			

8. Have you ever had (please check if yes):

Heart Trouble ☐	Pacemaker ☐	Kidney Disease ☐	Hepatitis ☐	Anemia ☐	Glaucoma ☐
Heart Attack ☐	High Blood Pressure ☐	Tumor/Cancer ☐	Tuberculosis ☐	Asthma ☐	Arthritis ☐
Heart Murmur ☐	Bleeding Problems ☐	Venereal Disease ☐	Diabetes ☐	Epilepsy ☐	Jaundice ☐
Rheumatic Fever ☐	Stomach Problems ☐	X-ray Treatment ☐	Stroke ☐	Ulcers ☐	AIDS ☐

9. Do you get up often at night to urinate? YES ☐ NO ☐
10. Are you thirsty much of the time? YES ☐ NO ☐
11. Has anyone in your family had diabetes? YES ☐ NO ☐
12. Do you smoke? YES ☐ NO ☐ How Much?____________
13. Do you consider yourself a nervous person? YES ☐ NO ☐
14. Do you take bisphosphonates? YES ☐ NO ☐
15. Do you have any disease, condition, or problem not listed above that you think we should know about? YES ☐ NO ☐
    a. If yes, explain:____
16. FOR WOMEN ONLY: Are you pregnant? YES ☐ NO ☐ If yes, what month?__________________________________

CONSENT:

I, the undersigned, hereby authorize Doctor to take radiographs, study models, photographs, or any diagnostic aides deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor with my verbal consent to perform any and all forms of treatment, medication, and therapy after he explains the condition in connection with (name of patient)____________________________________, and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand that use of anesthetic agents embodies risk. I understand that responsibility for **payment** for dental services provided in this office for myself and/or my dependants is mine, **due and payable at the time services are rendered**. If I do not pay the full balance at the time of service and/or have made financial arrangements for the balance, I understand that a 1.5% finance charge per month (18% annually) will be added to any balance over 90 days. **Furthermore, I understand that a cancellation fee will be charged unless 48 *working* hours notice is given for appointment changes.**

Signature:____ Date:____________________ Relationship to Patient:____________________

IN OFFICE USE ONLY
Health History Reviewed by: ____

Health History Update

CHANGES	DATE	PROVIDER'S SIGNATURE

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DENTAL HISTORY

Patient Name (please print) ______________________________ Date: ______________

Chief complaint or purpose of this appointment: ______________________________

Date of last dental visit: ______________ Purpose: ______________________________

Date of last dental cleaning: ______________________________

Date of last full mouth series of X-rays: ______________________________

Name of previous Dentist: ______________________________ City: ______________________________

	Yes	No
Are any of your teeth sensitive to:	☐	☐
Cold?	☐	☐
Heat?	☐	☐
Sweets?	☐	☐
Pressure?	☐	☐
When chewing, do you avoid one side?	☐	☐

If yes, Which? ______________________________

	Yes	No
Do your gums bleed when brushing?	☐	☐
Do you use a soft toothbrush?	☐	☐
Do you use dental floss?	☐	☐

If yes, How Often? ______________________________

	Yes	No
Does the floss catch or tear?	☐	☐

If yes, Where? ______________________________

	Yes	No
Do you have an unpleasant odor or taste in your mouth?	☐	☐
Do you grind or clench your teeth?	☐	☐
Do any of your teeth feel loose?	☐	☐

If yes, Which? ______________________________

	Yes	No
Do you ever awaken with pain near your ears or jaw muscles?	☐	☐
Do you hear clicking or popping when you chew?	☐	☐
Have you ever had orthodontic treatment?	☐	☐
Have	☐	☐
you ever been treated for a bad bite?	☐	☐

ACKNOWLEDGMENT
OF
PRIVACY PRACTICES

Jeffrey C. Derickson, D.D.S.
762 N. Country Club Rd.
Tucson, AZ 85716
Phone: 327-5993 / Fax: 327-0907

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

- ❑ Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- ❑ Obtain payment from third-party payers for my health care services.
- ❑ Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above 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 is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:____ **Date:** _________________

Signature:____

Relationship to Patient:____

Dependent family members also covered by this acknowledgement:

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- ❑ The patient refused to sign
- ❑ Communication barriers
- ❑ Emergency situation
- ❑ Other