The benefits of a happy, healthy smile are immeasurable!
Our goal is to help you reach and maintain maximum oral health.
Please fill out this form completely, so we may serve you better.

## 1 ABOUT YOU

Today's Date ______________________

**Name:** ______________________________________________
LAST FIRST MI MR MRS MS DR.

I prefer to be called: ____________________ ☐ Male ☐ Female

If child, parents name: ______________________________

Birthdate: __________ Age: ____ SS #: __________________

Home address: ______________________________

City/State/Zip: ______________________________

Email address: ______________________________

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Seperated

Home #: ______________________________

Wk #: ____________________________ Ext: __________

Cell #: ______________________________

**Employer:** ______________________________

Employer's address: ______________________________

City/State/Zip: ______________________________

Occupation: ______________________________

How long there? ______________________________

Where & when are best times to reach you? ________________

Who may we Thank for referring you? ________________

Purpose of this appointment? ________________

## 2 SPOUSE INFORMATION

Spouse Name: ______________________ Birthdate: ________

Employer: ______________________ Occupation: ______

Address: ______________________________

City/State/Zip: ______________________________

Wk #: ________________ Ext: ____ SS #: ______________

Cell #: ______________________________

Person Responsible for Account: ______________________

☐ If patient is responsible party, please check this box and go on to Section 3.

Wk #: ______________ Ext: _____ Hm #: ______________

Billing Address: ______________________________

City/State/Zip: ______________________________

Relationship: ______________ SS #: ______________

Employer: ______________________ Birthdate: __________

## 3 DENTAL INSURANCE

**Primary Dental Insurance**

Insurance Co. Name: ______________________________

Insurance Co. Phone #: ______________________________

Insured's Name: ______________________ Relation: ________

Insured's Birthdate: ________ Insured's SS #: ________________

Insured's Employer: ______________________________
IF RETIRED, USE LAST EMPLOYER

Address: ______________________________

City/State/Zip ______________________________

**Secondary Dental Insurance**

Insurance Co. Name: ______________________________

Insurance Co. Phone #: ______________________________

Insured's Name: ______________________ Relation: ________

Insured's Birthdate: ________ Insured's SS #: ________________

Insured's Employer: ______________________________
IF RETIRED, USE LAST EMPLOYER

Address: ______________________________

City/State/Zip ______________________________

I authorize the release of information necessary for the processing of insurance claims and assign benefits to Dr. Charles C. Clausen, D.D.S., P.C.

Signature: ______________________________

In case of emergency, whom should be notified? ________________

______________________________

______________________________

Phone #: ______________________________

## 4 FINANCIAL RESPONSIBILITY

I acknowledge that I am responsible for all charges for services provided, including any amount not paid by my insurance plan. If collection procedures become necessary I agree to pay all attorney and collection fees.

I acknowledge I have received a copy of this office's Notice of Privacy Practices.

I also authorize the release of all dental information necessary for processing insurance claims to my insurers or any third party or their agents.

I understand that 48 business hours notice for cancellations is required or a fee of $75 will be charged.

______________________________________________
PATIENT/INSURED SIGNATURE DATE

## 5 MEDICAL / DENTAL HISTORY

Physician's Name: ______________________________

Phone #: ______________ Date of last visit: ______

Height: ______ Weight: ______ Blood Pressure: ________

**Your current physical health is:** ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ No ☐ Yes

Please explain: ______________________________

Are you taking any medications? ☐ No ☐ Yes

Are you taking any herbal supplements? ☐ No ☐ Yes

Please list each one: ______________________________

When was your last dental appointment? ______________

When was your last full mouth X-Ray taken? ______________

Where? ______________________________

**For Women:** Are you taking any birth control pills? ☐ No ☐ Yes

Are you pregnant? ☐ No ☐ Yes Week #: __________

Are you nursing? ☐ No ☐ Yes

**Do you have or have you ever had:**

- Blood Transfusion ☐ No ☐ Yes
- Severe/Frequent headaches ☐ No ☐ Yes
- Pain in or near your ears ☐ No ☐ Yes
- Growth or sore spots in your mouth ☐ No ☐ Yes
- Mouth hurts when clenched ☐ No ☐ Yes
- Gums bleed ☐ No ☐ Yes
- Do you at the present time have any dental complaints ☐ No ☐ Yes
- Do you habitually clench your teeth during the night or day ☐ No ☐ Yes
- Any part of your mouth sore to pressures or irritants (cold, sweets, etc.) ☐ No ☐ Yes
- Do you use tobacco products ☐ No ☐ Yes

**Are you allergic to:**

- Penicillin ☐ No ☐ Yes
- Local anesthetic ☐ No ☐ Yes

Other medications or drugs: ______________________________

Have you been hospitalized in the last 5 years? ☐ No ☐ Yes

If so, for what ______________________________

## 6 MEDICAL / DENTAL HISTORY Cont.

**Do you have or have you ever had:**

- Do you ever get sleepy in the afternoon? ☐ No ☐ Yes
- Do you wake-up frequently? ☐ No ☐ Yes
- Do you ever wake-up feeling unrested? ☐ No ☐ Yes
- HIV Positive ☐ No ☐ Yes
- Anemia ☐ No ☐ Yes
- Asthma ☐ No ☐ Yes
- Diabetes ☐ No ☐ Yes
- Epilepsy ☐ No ☐ Yes
- Hepatitis ☐ No ☐ Yes
- Rheumatic Fever ☐ No ☐ Yes
- Artificial Joints ☐ No ☐ Yes
- Heart Murmur ☐ No ☐ Yes
- Mitral Valve Prolapse ☐ No ☐ Yes
- Abnormal Heart Condition ☐ No ☐ Yes
- Abnormal Bleeding From A Cut ☐ No ☐ Yes
- Abnormal Blood Pressure ☐ No ☐ Yes
- Respiratory Disease ☐ No ☐ Yes
- Pulmanory Shunts ☐ No ☐ Yes
- Rheumatism or Arthritis ☐ No ☐ Yes
- Tumors or Growths ☐ No ☐ Yes
- Any Blood Disease ☐ No ☐ Yes
- Any Liver Disease ☐ No ☐ Yes
- Any Kidney Disease ☐ No ☐ Yes
- Any Stomach or Intestinal Disease ☐ No ☐ Yes
- Any Venereal Disease ☐ No ☐ Yes

## 7 APPEARANCE SATISFACTION

Are you satisfied with the appearance of your teeth? ☐ No ☐ Yes

If NO, what concerns do you have about the appearance of your teeth?

______________________________

What changes, if any, would you like to make to your smile? __________

______________________________

**Dr. Charles C. Clausen, D.D.S., P.C**
**13055 W McDowell Rd**
**Avondale AZ 85323**

# NOTICE OF PRIVACY POLICY

The office of Dr. Charles C. Clausen, is dedicated to protecting your "nonpublic personal health information". This notice is to tell you how and why we collect that information and who has access to that information.

***HOW AND WHY WE COLLECT YOUR INFORMATION*:**
Your personal demographic information such as name, address, birth date, social security number and medical /dental insurance information is obtained from you. This is why we ask you to fill out the patient information sheet and why we ask for a copy of your insurance card. This ensures that the information we collect is correct.

We may also ask a doctor or other health care provider who referred you to this practice to give us health information that will enable us to better treat you.

We collect this information so that we can treat your dental condition and obtain payment from you or your insurance.

***WHO HAS ACCESS TO THIS INFORMATION*:**
Any person or person you designate in writing, people directly involved in your care, people creating and maintaining your medical records, and those that need your information to process insurance claims and obtain payment for services rendered.

Entities such as Governmental Oversight agencies, Judicial and Administrative Proceedings, Law Enforcement Agencies, Coroners and Medical Examiners, may obtain copies of your protected health information.

***HOW WE PROTECT YOUR INFORMATION*:**
We release your information only to those people who need your information. We maintain physical, electronic, and procedural safeguards so that no one but persons involved in your healthcare or entities that need this information for claims processing have access to your protected healthcare information.

***YOUR RIGHTS*:**
You have the right to request we amend your health information. (Your request must be made in writing and explain why the information should be amended). You have the right to obtain copies of your health information, with limited exceptions. If you request copies, we will charge you $1.00 for each page, and $15/hour staff time to locate and copy your health information.

If you feel your privacy may have been violated you may file a written complaint at our office. You may also submit a written complaint to the U.S. Department of Health and Human Services.