SUN VALLEY DENTAL GROUP
BRIAN GALBRAITH, D.D.S

Welcome!

Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you. Thank You!

PATIENT INFORMATION

Name________________________ Soc. Sec. # ________________________

How Do you prefer to be addressed? ________________________

Email________________________ Cell Phone________________________

Mailing Address________________________ Home Phone ________________________

City________________________ State________________________ Zip Code________________________

Sex M ☐ F ☐ Age____________ Birthdate________________ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐

Patient Employed By________________________ Occupation________________________

Business Address ________________________ Business Phone ________________________

Whom May We Thank For Referring You? ________________________

Previous Dentist________________________ Business Phone________________________

Person to Notify in case of Emergency ________________________ Phone ________________________

PRIMARY INSURANCE

Person Responsible for Account________________________

Relation to Patient________________ Soc. Sec. #________________ Birthdate________________

Address ________________________ Phone________________________

City________________________ State________________________ Zip Code________________________

Person Responsible Employed By________________________ Occupation ________________________

Business Address________________________ Business Phone ________________________

Insurance Company ________________________

Address ________________________ Phone ________________________

Plan #________________________ Group # ________________________

Name of Other Dependents Under This Plan ________________________

MEDICAL HISTORY

Do you have a personal physician? ________________________ Physician's Name________________________

Phone #________________________ Date of last visit ________________________

Are you currently under the care of a physician? ____________ Please Explain ________________________

Your current physical health is ☐ Good ☐ Fair ☐ Poor

Have you taken Fosamax, Actonel, Boniva or any other bisphospanates? ☐ Yes ☐ No

- Do you smoke or use tobacco in any form? ☐ Yes ☐ No

Do you take, or have you taken Phen-Fen or Redux? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription or over the counter herbal supplements?

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FOR WOMEN: Are you using a prescribed method of birth control ☐Yes ☐No

Are you pregnant? ☐ Yes ☐ No

Are you Nursing? ☐ Yes ☐ No

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

Are you on a special Diet? ☐ Yes ☐ No If yes please explain________________________

Y N AIDS/ HIV POSITIVE
Y N Alzheimer's Disease
Y N Anaphylaxis
Y N Anemia
Y N Angina
Y N Arthritis/ Gout
Y N Artificial Heart Valve
Y N Artificial Joint
Y N Asthma
Y N Blood Disease
Y N Blood Transfusion
Y N Breathing Problems
Y N Bruise Easily
Y N Cancer
Y N Chemotherapy
Y N Chest Pains
Y N Cold Sores / Fever Blisters
Y N Congenital Heart Disorder
Y N Heart Trouble
Y N Pace Maker

Y N Cortisone Medicine
Y N Diabetes
Y N Drug Addiction
Y N Easily Winded
Y N Emphysema
Y N Epilepsy or Seizures
Y N Excessive Bleeding
Y N Excessive Thirst
Y N fainting spells/ Dizziness
Y N Frequent Cough
Y N Frequent Diarrhea
Y N Frequent Headaches
Y N Genital Herpes
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack/Failure
Y N Heart Murmur
Y N Parathyroid Disease
Y N Psychiatric Care

Y N Hospitalized for any Reason
Y N Hemophilia
Y N Hepatitis A
Y N Hepatitis B or C
Y N Herpes
Y N High Blood Pressure
Y N High Cholesterol
Y N Hives or Rash
Y N Hypoglycemia
Y N Irregular Heartbeat
Y N Kidney Problems
Y N Leukemia
Y N Liver Disease
Y N Low Blood Pressure
Y N Lung Disease
Y N Mitral Valve Prolapse
Y N Osteoporosis
Y N Pain in Jaw/Joints
Y N Ulcers

Y N Radiation Treatments
Y N Recent Weight Loss
Y N Renal Dialysis
Y N Rheumatic Fever
Y N Rheumatisim
Y N Scarlet Fever
Y N Shingles
Y N Sickle Cell Disease
Y N Sinus Trouble
Y N Spina Bifida
Y N Stomach Disease
Y N Stroke
Y N Swelling of Limbs
Y N Thyroid Disease
Y N Tonsillitis
Y N Tuberculosis
Y N Tumors or Growths
Y N Convulsions
Y N Yellow Jaundice

Have you ever had any serious illness not listed? ☐ Yes ☐ No If yes ________________

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics ☐ Erythromycin

Other ________________

Do you use Controlled Substances? ☐ Yes ☐ No If Yes ________________

DENTAL HISTORY

Immediate Dental Concerns ________________

2. Do your gums bleed when you brush? ________________
3. How often do you brush your teeth? ________________
4. Do your gums ever feel swollen & tender? ________________
5. Do sweets, hot or cold cause pain in your mouth? ________________
6. Have you ever had periodontal disease? ________________
7. Do you have popping / pain in your jaw? ________________
8. Does food catch between your teeth? ________________
9. Do you have any swelling or lumps in your mouth? ________________
10. Do you grind your teeth at night? ________________
11. Do you currently have any pain in your mouth? ________________

12. Are you satisfied with the appearance, shape and color of your teeth? ________________

Do you wish to have fluoride treatment? Yes ________ NO ________

SMILE HISTORY

Do you smile with confidence? ☐ Yes ☐ No
Have you ever worn braces or Invisalign ☐ Yes ☐ No
Have you ever tried teeth whitening? ☐ Yes ☐ No
Have you ever had a professional smile consultation? ☐ Yes ☐ No

I have Received HIPPA Information ____________ **Signature** ________________ **Date**____________

WE ARE GLAD YOU ARE HERE! WE'LL TAKE GOOD CARE OF YOU

Welcome!

Prior to scheduling dental treatment (other than an exam, x-rays, and cleaning appointments) payment is collected in full.

We offer the following financial options. Please let us know if you have any questions.

1. **We accept Cash, Check, Visa, MasterCard, American Express and Discover Cards.**
2. **Care credit:** For treatment **over $300.00**. You can apply online or while in our office and approval is known within a few minutes. Care Credit offers 3, 6, 12 and 18 month interest free plans. There is no down payment required, no annual fees and no pre-payment penalty for this plan.
3. **Lending Club:** For treatment **over $499.00**. You can apply online or in office and approval is also known quickly. Payments can be stretched over 6-84 months. There is no upfront payment and first payment is not due for 3-7 weeks. This plan also offers no pre-payment penalties.
4. **Dental Insurance:** We are happy to submit your dental claims to your carrier. Please know that variables exist (i.e. deductibles, annual maximums, allowable fee limitations, non-coverage procedures and other restrictions). Therefore, we cannot guarantee any estimated charges. Most dental insurance plans do not cover 100% of your cost of treatment. Because your insurance is an agreement between you and your insurance company, ultimately you are responsible for all coverage and any outstanding balance.

Patient Name: ____

Signature:______________________________ Date: ______________________