Hi! Just a note to welcome you to the practice; we are looking forward to meeting you!
We will do our best to make your first visit as comfortable and informative as possible.
Please feel free to ask questions at any time regarding your treatment procedures, preventative services, fees or any other aspect of dentistry. It is our goal to provide you with the highest quality of dentistry, which will be of lasting value.

During the initial exam we will be taking needed x-rays, digital photos, checking your bite, checking all teeth and tissue, and taking notes of all the areas of concern. The exam also includes an oral cancer screening test. The initial exam appointment will take approximately an hour and a half to complete.

If you would like to download the initial new patient forms, please do so. They are located under the "New Patients" tab on our website: www.AdvancedDentistryByDesign.com. Otherwise please arrive fifteen minutes prior to your appointment to fill out these forms.

Your second appointment, which will be scheduled at a later date, will be a hygiene evaluation. This appointment is an hour long, and will include measuring the gum and bone levels to determine your gingival heath. We will then use the information gathered to build a customized periodontal program that will best suit you and your dental needs.

If you are transferring from another dentist, please acquire any current x-rays prior to your initial visit, as they could be useful for comparison purposes. We are happy to assist you in acquiring these. Please let us know 48 hours prior to your appointment at our office if you'd like our help.

We are committed to giving our patients the highest level of care in a safe and comfortable environment. We are pleased that you have chosen Advanced Dentistry by Design to help you reach your dental goals. We look forward to seeing you soon.

PHONE: 775-883-7244
403 W. NYE LANE, SUITE A, CARSON CITY, NV 89706
WWW.ADVANCEDDENTISTRYBYDESIGN.COM

Who can we thank for referring you to us?

Newspaper?	☐ Yes
Online?	☐ Yes
Billboard?	☐ Yes
Mailer?	☐ Yes
Yellow Pages Online/Book	☐ Yes
Carson Telephone Directory?	☐ Yes
Friend or family member?	☐ If yes, who? _____
Someone who works here?	☐ If yes, who? _____
Another doctor?	☐ If yes, who? _____
Other?	☐ If yes, where? _____

While you are with us for your appointment, we would be pleased to schedule new patient appointments for your family members also. Please let us know if you have any questions or if we can do anything to make your visit with us a more comfortable one.

Sincerely,

The Entire Team
Advanced Dentistry by Design

PHONE: 775-883-7244
403 W. Nye Lane, Suite A, Carson City, NV 89706
www.AdvancedDentistryByDesign.com

PATIENT REGISTRATION

PATIENT INFORMATION

First Name: _____Last Name: _____ Middle Initial: _____
Preferred Name: _____ Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed
Address:_____
City, State, Zipcode:_____
Home Phone:_____ Cell Phone:_____ Work Phone: _____ Ext:_____
Birth Date:_____ Sex: Male☐ Female☐ Social Security: _____
Driver's License#:_____ Driver's License State: _____ Is Patient a Minor? _____
Email: _____ May we send e-mail correspondence? Yes☐ No☐

PARENT/RESPONSIBLE PARTY INFORMATION (IF PATIENT IS A CHILD)

First Name: _____ Last Name: _____ Middle Initial: _____
Preferred Name: _____ Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed
Address: _____
City, State, Zipcode: _____
Home Phone: _____ Cell Phone:_____ Work Phone: _____ ext: _____
Birth Date:_____ Social Sec:_____ Driver's License #:_____ State: ___
Relationship to Patient_____ Driver's License #:_____ Driver's License State _____

INSURANCE INFORMATION

Primary Insurance Information
Name of Insured:_____Relationship to Patient: Self☐ Spouse☐ Child☐
Insured Soc. Sec. _____ Insured Birth Date: _____
Employer:_____
Employer Address: _____
City, State, Zipcode:_____
Insurance Company/Address: _____

Secondary Insurance Information
Name of Insured:_____ Relationship to Patient: Self☐ Spouse☐ Child☐
Insured Soc. Sec. _____ Insured Birth Date: _____
Employer:_____
Employer Address: _____
City, State, Zipcode:_____
Insurance Company/Address: _____

Has the patient used any dental insurance benefits in another dental office for this insurance year? _____
Has the patient had a dental exam or x-rays in another office during this insurance year? _____
Are you interested in information about discount programs for uninsured patients or financing? _____

CONSENT FOR DENTAL SERVICES

1) I hereby authorize doctor (or designated staff) to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient)_____'s dental needs.
2) I understand that the use of anesthetics and sedatives may be necessary, and with their use embodies certain risks. I am aware that by my request, I am entitled to a complete recital of potential complications.
3) I am aware that as a courtesy, Advanced Dentistry by Design's staff will bill my dental insurance. If a dental pre-authorization has not been submitted the quoted out of pocket expense will be based on the majority of dental plans. It is not uncommon for insurance companies to have wait periods and exclusions on certain procedures. It is my responsibility to review my plan booklet or check with my insurance company to be sure that my scheduled care falls within their guidelines and my amount of insurance available.
4) I agree to be responsible for payments of all services rendered on behalf of myself or my dependants. I am ultimately responsible for any amount on my account not paid by my insurance company. I understand that payment is due at the time of service and no in-office financing is available. A long term payment program is available upon proven credit.
5) I am aware if there are balances that remain on my account past 30 days I will be charged a late fee of 21% APR.
6) I agree to notify the office as soon as possible if something arises and I need to reschedule an appointment. I am aware that if I miss three appointments without informing the office prior, I may be dismissed from the practice.
7) If required, I authorize Advanced Dentistry by Design to check my credit.
8) There will be a $25.00 charge on all returned checks.
9) I have had the opportunity to read and I understand the privacy policies of Advanced Dentistry by Design. You have my permission to discuss my dental appointments and treatment with the following people:

_____

Name Relationship to Patient Phone Number

_____

Name Relationship to Patient Phone Number

Signature_____Date_____

Relationship to Patient_____

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403 W. NYE LANE, SUITE A, CARSON CITY, NV 89706
WWW.ADVANCEDDENTISTRYBYDESIGN.COM

Advanced Dentistry By Design

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	☐ Yes ☐ No	If yes
Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No	If yes
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	If yes
Are you taking any medications, pills, or drugs?	☐ Yes ☐ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes ☐ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes ☐ No	If yes
Are you on a special diet?	☐ Yes ☐ No	
Do you use tobacco?	☐ Yes ☐ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

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

Do you use controlled substances?	☐ Yes ☐ No	If yes
Other?	☐	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ☐ Yes ☐ No	Cortisone Medicine ☐ Yes ☐ No	Hemophilia ☐ Yes ☐ No	Radiation Treatments ☐ Yes ☐ No
Alzheimer's Disease ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Hepatitis A ☐ Yes ☐ No	Recent Weight Loss ☐ Yes ☐ No
Anaphylaxis ☐ Yes ☐ No	Drug Addiction ☐ Yes ☐ No	Hepatitis B or C ☐ Yes ☐ No	Renal Dialysis ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Easily Winded ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
Angina ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Rheumatism ☐ Yes ☐ No
Arthritis/Gout ☐ Yes ☐ No	Epilepsy or Seizures ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Artificial Heart Valve ☐ Yes ☐ No	Excessive Bleeding ☐ Yes ☐ No	Hives or Rash ☐ Yes ☐ No	Shingles ☐ Yes ☐ No
Artificial Joint ☐ Yes ☐ No	Excessive Thirst ☐ Yes ☐ No	Hypoglycemia ☐ Yes ☐ No	Sickle Cell Disease ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Fainting Spells/Dizziness ☐ Yes ☐ No	Irregular Heartbeat ☐ Yes ☐ No	Sinus Trouble ☐ Yes ☐ No
Blood Disease ☐ Yes ☐ No	Frequent Cough ☐ Yes ☐ No	Kidney Problems ☐ Yes ☐ No	Spina Bifida ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No	Frequent Diarrhea ☐ Yes ☐ No	Leukemia ☐ Yes ☐ No	Stomach/Intestinal Disease ☐ Yes ☐ No
Breathing Problems ☐ Yes ☐ No	Frequent Headaches ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Bruise Easily ☐ Yes ☐ No	Genital Herpes ☐ Yes ☐ No	Low Blood Pressure ☐ Yes ☐ No	Swelling of Limbs ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Lung Disease ☐ Yes ☐ No	Thyroid Disease ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No	Hay Fever ☐ Yes ☐ No	Mitral Valve Prolapse ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Chest Pains ☐ Yes ☐ No	Heart Attack/Failure ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Cold Sores/Fever Blisters ☐ Yes ☐ No	Heart Murmur ☐ Yes ☐ No	Pain in Jaw Joints ☐ Yes ☐ No	Tumors or Growths ☐ Yes ☐ No
Congenital Heart Disorder ☐ Yes ☐ No	Heart Pacemaker ☐ Yes ☐ No	Parathyroid Disease ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Convulsions ☐ Yes ☐ No	Heart Trouble/Disease ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
Yellow Jaundice ☐ Yes ☐ No			

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

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

DENTAL HISTORY

Name: _____ Date: _____

1. Are you having any discomfort at this time? ☐Y or ☐N
   Describe:

2. How long since your last dental visit? _____
3. Did you have x-rays taken? _____
4. What was done at your last dental appointment? _____
5. Have you lost any teeth? _____
6. Any complications with extractions? _____
7. Have the missing teeth been replaced by: Bridges, Implants, or Dentures? ☐Y or ☐N
   If yes, please list:_____
8. Are your teeth sensitive to: ☐Heat / ☐Cold / ☐Sweets / ☐Sour?
9. Have you had your teeth straightened? ☐Y or ☐N
10. Are you happy with your smile? ☐Y or ☐N
11. Do you wish your teeth were whiter? ☐Y or ☐N
12. Do you floss? ☐Y or ☐N How often? _____
13. How long have you been flossing? _____
14. Do you use a Sonic toothbrush? ☐Y or ☐N
15. Other home care aids? _____
16. Do you drink beverages other than water? ☐Y or ☐N
    How many per day? _____
17. Do you snack in between meals? ☐Y or ☐N
18. Do you have bleeding gums? ☐Y or ☐N Where? _____
19. Does food wedge between your teeth? ☐Y or ☐N Where? _____
20. Have you ever had gum treatments? ☐Y or ☐N
21. Do you grind? ☐Y or ☐N / Clench your teeth? ☐Y or ☐N / When? _____
22. Do you have a night guard? ☐Y or ☐N
23. Do you hear clicking/popping? ☐Y or ☐N
24. Has your jaw ever locked open/closed? ☐Y or ☐N When? _____
25. Any pain around your ears? ☐Y or ☐N
26. Do you have headaches more than once weekly? ☐Y or ☐N
27. Do you have any fear of having dentistry done? ☐Y or ☐N
    Explain: _____
28. How do you feel about your teeth? _____
29. Do you want to avoid full dentures? _____
30. Please rank the following in order of importance to you:
    Health (pain-free; no cavities); Function; Beauty (Esthetics)

31. Any additional comments:

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