Welcome to Fairview Dental! Thank you for choosing our office for your dental care. Please complete this form as accurately as possible. The information you provide helps us deliver safe, personalized treatment. If anything changes regarding your health or contact information, please let us know. If you have any questions while completing these forms, our team is happy to help.

Patient Information

Date _____/_____/_____ Patient's Name _____ Preferred Name _____

Home Address _____ City _____ State _____ ZIP _____

☐ Billing address is the same as above

If different: Billing Address _____ City _____ State _____ ZIP _____

Home Phone# _____ Work Phone# _____ Cell Phone# _____

SSN# _____-_____-_____ Driver's Lic.# _____ Email Address _____

Date of Birth _____/_____/_____ Sex __ M __ F Marital Status _____ If minor, parent/guardian's name _____

Emergency Contact _____ Relationship _____ Phone#_____

Pharmacy Name _____ Address _____

Responsible Party *(Complete only if different from the patient.)*

Full Name _____

SSN# _____-_____-_____ Date of Birth _____/_____/_____ Relationship_____

Home Address _____ City _____ State _____ ZIP _____

Employer _____ Occupation _____ # of Years Employed _____

Work Address _____ City _____ State _____ ZIP _____

Insurance Information

Primary Dental Insurance Company _____ Subscriber Name _____

Member ID# _____ Group Number _____Subscriber Date of Birth _____/_____/_____

Secondary Dental Insurance Company _____ Subscriber Name _____

Member ID# _____ Group Number _____Subscriber Date of Birth _____/_____/_____

Name of previous dentist _____ Date of last visit _____/_____/_____

***** How did you hear about us?** _____

Fairview DENTAL

Your health and safety are our top priorities. Please answer the following questions as accurately as possible.

1. Are you experiencing any pain, swelling, or discomfort today? ☐ Yes ☐ No

2. Have you been hospitalized or had surgery within the past two years? ☐ Yes ☐ No

3. Are you currently taking any prescription medications, over-the-counter medications, vitamins, or supplements? ☐ Yes ☐ No

If yes, please list them: _____

4. A) Have you taken any medications within the past two years? ☐ Yes ☐ No

B) Have you ever taken bisphosphonate medications (such as Fosamax®, Boniva®, Reclast®, Prolia®, etc.) for osteoporosis or another bone condition? ☐ Yes ☐ No

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

Physician _____ Phone# _____

7. Do you have any allergies or sensitivities to medications, latex, anesthetics, or metals? ☐ Yes ☐ No

If yes, please list them:_____

8. Please check any medical conditions that you had in the past as well as currently have. If none apply, leave this section blank.

☐ AIDS	☐ Cold Sores / Fever Blisters	☐ Heart Pacemaker	☐ Radiation Therapy
☐ Allergies / Hives	☐ Congenital Heart Disease	☐ Heart Surgery	☐ Rheumatic Fever
☐ Anemia	☐ Cortisone Medicine	☐ Hemophilia	☐ Rheumatism
☐ Angina Pectoris	☐ Developmentally Disabled	☐ Hepatitis	☐ Sickle Cell Disease
☐ Arteriosclerosis	☐ Diabetes	☐ Hepatitis Type: **A B C**	☐ Sinus Trouble
☐ Arthritis	☐ Drug Addiction	☐ High Blood Pressure	☐ Stroke
☐ Artificial Heart Valve	☐ Emphysema	☐ HIV Positive	☐ Thyroid Problem
☐ Artificial Joint	☐ Epilepsy / Seizures	☐ Kidney Trouble	☐ Tuberculosis
☐ Asthma	☐ Fainting / Dizzy Spells	☐ Latex Allergy	☐ Tumors
☐ Blood Transfusion	☐ Glaucoma	☐ Liver Disease	☐ Ulcers
☐ Bruise Easily	☐ Hay Fever	☐ Metal Allergy (Jewelry, etc.)	☐ Venereal Disease
☐ Cancer	☐ Heart Disease or Heart Attack	☐ Mitral Valve Prolapse	☐ Yellow Jaundice
☐ Chemotherapy	☐ Heart Failure	☐ Nervousness	
☐ Chronic Cough	☐ Heart Murmur	☐ Osteoporosis	

9. Do you experience chest pain, shortness of breath, or excessive fatigue when walking or climbing stairs? ☐ Yes ☐ No

10. Do your ankles swell during the day? ☐ Yes ☐ No

11. Do you sleep with more than two pillows? ☐ Yes ☐ No

12. Have you gained or lost more than 10 pounds within the past year? ☐ Yes ☐ No

13. Do you ever wake up short of breath? ☐ Yes ☐ No

14. Are you following a special diet? ☐ Yes ☐ No

15. Do you currently smoke or use tobacco products? ☐ Yes ☐ No

16. Do you have any other medical conditions or health concerns that we should know about? ☐ Yes ☐ No

If yes, please list them:_____

I certify that the information I have provided is accurate and complete to the best of my knowledge. I understand that this information is necessary for my dental treatment and that I am responsible for informing Fairview Dental of any changes to my medical history, medications, or health status.

Patient/Guardian Signature _____ Print Name _____ Date _____/_____/_____

For Office Use: Reviewed by Dr. _____ Date _____/_____/_____

Initials _____

Treatment Consent

I authorize the doctor and dental team to take X-rays, photographs, study models, and other diagnostic records necessary to evaluate my dental condition and develop an appropriate treatment plan. I authorize the doctor to perform the dental treatment that has been discussed and agreed upon. I understand that dental procedures, local anesthetics, and prescribed medications may involve risks and complications, and I consent to their use as needed during my treatment. I agree to notify Fairview Dental of any changes to my medical history, medications, contact information, or insurance coverage.

Initials _____

Financial Responsibility & Insurance

I understand that I am responsible for payment of all dental services provided unless other financial arrangements have been made in advance. As a courtesy, Fairview Dental will submit dental insurance claims on my behalf. I authorize Fairview Dental to use my insurance information, including my Social Security Number or insurance identification number when required for claim processing purposes. Insurance benefits are estimated and not guaranteed, and any balance remaining after insurance payment is my responsibility. Accounts not paid as agreed may be subject to finance charges, billing fees, collection costs, court costs, attorney fees, and other applicable charges permitted by law.

Initials _____

Appointment Policies

Appointments are reserved specifically for you with Dr. Luu or a member of our Hygiene Team. A deposit may be required when scheduling treatment appointments, with the amount based on the length of time reserved.

If you need to cancel or reschedule an appointment, the following minimum notice is required:

- **2 complete business days for appointments up to 60 minutes**
- **4 complete business days for appointments lasting 90–120 minutes**
- **5 complete business days for appointments lasting 3 hours or longer**

To cancel or reschedule, you must speak directly with a member of our office staff during normal business hours. Messages left after business hours or not personally received by office staff do not constitute adequate notice. **Appointments cancelled without the required notice, or missed appointments, will be charged $50 for each 30 minutes of reserved appointment time.**

Office Hours: Tuesday–Friday 9:30 AM–6:00 PM | Saturday 8:00 AM–4:00 PM

Initials _____

Additional Office Policies

Children's Appointments: For very young children, we welcome one parent to accompany them during the initial examination. For future appointments, we may ask parents to remain in the reception area while treatment is provided. For the safety and privacy of all patients, siblings and other children must remain in the reception area with a supervising adult.

Payment Options: We accept Cash, Visa, Mastercard, Discover, American Express, and CareCredit. **A 3% processing fee applies to debit and credit card payments and will be waived when payment is made in full at the time of service.**

Cell Phone Use: Cell phone use is not permitted during treatment appointments with Dr. Luu or our Hygiene Team.

Release of Records: Complete dental records require a signed authorization and a **$50 processing fee**.

Billing & Collections: Accounts with balances outstanding more than 30 days from the date of service may be charged a $5 billing statement fee and may accrue additional interest or fees as permitted by law. If an account is referred to a collection agency or attorney for recovery, the responsible party agrees to pay all collection costs, court costs, attorney fees, and other expenses associated with collection efforts.

Patient Acknowledgment - By signing below, I acknowledge that I have read, understand, and agree to the Treatment Consent, Financial Responsibility, Insurance Authorization, and Office Policies outlined above.

Patient Name (Print) _____ Patient Signature _____Date _____/_____/_____

Guardian/Responsible Party (*if applicable*) _____Signature _____

Relationship _____ Date _____/_____/_____

Consent for Use and Disclosure of Health Information (HIPAA)

Please read the following information carefully.

Fairview Dental may use and disclose your Protected Health Information (PHI) for purposes of treatment, payment, and healthcare operations, as permitted by applicable law.

Examples include:

- Providing and coordinating your dental treatment
- Processing and collecting payment for services rendered
- Conducting office administration, quality assessment, and other healthcare operations

By signing below, you authorize Fairview Dental to use and disclose your Protected Health Information as described above and in our Notice of Privacy Practices.

Notice of Privacy Practices - You have the right to review our Notice of Privacy Practices before signing this form. The Notice of Privacy Practices explains:

- How your Protected Health Information may be used and disclosed
- Your privacy rights regarding your health information
- Our legal duties concerning the protection of your health information

A copy of our Notice of Privacy Practices is available upon request. We encourage you to read it carefully.

Fairview Dental reserves the right to revise its privacy practices and Notice of Privacy Practices as permitted by law. Any revisions may apply to all Protected Health Information maintained by our office. The most current version is available upon request.

Right to Revoke - You may revoke this authorization at any time by submitting a written request to the Office Manager. Revocation will not apply to actions already taken in reliance on this authorization before we receive your written request. Please note that revoking this consent may affect our ability to provide or continue treatment.

Patient Consent - I have had the opportunity to read and consider the contents of this form and the Notice of Privacy Practices. I understand how my Protected Health Information may be used and disclosed for treatment, payment, and healthcare operations. By signing below, I consent to these uses and disclosures.

Patient Name (Print) _____ Patient Signature _____ Date _____/_____/_____

If Signed by Parent, Guardian, or Personal Representative

Name (Print) _____ Relationship to Patient _____

Signature _____ Date _____/_____/_____

Acknowledgment of Receipt of Notice of Privacy Practices - I acknowledge that I have been offered a copy of Fairview Dental's Notice of Privacy Practices. **(You are entitled to receive a copy of this consent form and our Notice of Privacy Practices for your records. Please let us know if you would like a copy)**

Patient Name (Print) _____ Patient Signature _____ Date _____/_____/_____

Dental Photography & Media Authorization

Patient Name _____ Date _____ / _____ / _____

Purpose of Dental Photography

During the course of your dental care, photographs, videos, or digital images of your teeth, mouth, smile, and/or face may be taken. These images may be used to:

- Document your dental condition and treatment progress
- Assist with treatment planning and patient education
- Support professional education and training
- Illustrate dental procedures and treatment outcomes for other patients

With your permission, images may also be used in practice marketing and educational materials, including:

- Fairview Dental's website
- Social media platforms
- Printed materials (brochures, flyers, and office displays)
- Educational presentations and professional training
- Other online or digital marketing materials

Authorization - Please select **ONE** option below:

☐ **YES,** I authorize Fairview Dental to use photographs, videos, and digital images taken during my care for treatment documentation, patient education, professional training, and marketing or promotional purposes.

☐ **NO,** I **do not** authorize Fairview Dental to use my photographs, videos, or digital images for educational, marketing, or promotional purposes outside of my dental record and treatment documentation.

Important Information

- Your decision is completely voluntary and will not affect the quality of care you receive.
- You may revoke your authorization at any time by submitting a written request to Fairview Dental.
- Revocation will apply only to future uses of images and cannot remove materials already published, distributed, or otherwise in circulation before the revocation was received.

Patient Authorization - I have read and understand this authorization form and have selected my preference above.

Patient Signature _____ Date ____ / ____ / _____

If Patient is Under 18 Years of Age

Parent/Guardian Name (Print) _____ Parent/Guardian Signature _____

Relationship to Patient _____ Date ____ / ____ / _____

Office Representative _____ Date ____ / ____ / _____

Handle Me With Care

We understand that every patient is different. Please check any items that apply to you so we can make your visit as comfortable as possible.

☐ I gag easily.

☐ I feel out of control when I am lying down in the dental chair.

☐ I have not been to the dentist for a long time, and I feel uncomfortable about what the doctor may say about my teeth and dental hygiene.

☐ I know I have habits that are causing harm to my dental health, and I am concerned about my ability to change them.

☐ Pain relief is a top priority to me.

☐ I don't like shots, or I have had bad reactions to shots in the past.

☐ Please tell me what I need to know about my mouth so I can make an informed decision about my treatment.

☐ My teeth are very sensitive.

☐ I don't like the sound of tools picking and scraping my teeth.

☐ I don't like cotton in my mouth.

☐ I hate the noise of the drill.

☐ I don't like dental office smells.

☐ Please respect my time. I don't want to be left waiting in the reception area.

☐ I want to know the cost up front. No financial surprises.

☐ I have difficulty listening to and remembering information while sitting in the dental chair.

☐ I have health problems or questions that we need to discuss.

☐ I don't like being left alone in the treatment area.

☐ I have problems with my back.

☐ I don't like the chair tipped too far back.

☐ I don't like to see dental instruments.

☐ I need to talk with you first before sitting in the dental chair.

☐ Other concerns I would like to discuss:

_____

_____

_____