Garon Larsen D.M.D
Advanced Dentistry | Personal Care

Please fill out both sides of this form completely

PATIENT INFORMATION

PATIENT NAME _____
HOME ADDRESS _____
(City, State, Zip) _____
HOME PHONE _____
CELL PHONE _____
E-MAIL _____
DATE OF BIRTH _____
SOCIAL SECURITY NO. _____

❍ MARRIED ❍ SINGLE ❍ MALE ❍ FEMALE

RESPONSIBLE PARTY

NAME _____
ADDRESS _____
(City, State, Zip) _____
EMPLOYER _____
WORK PHONE _____
SPOUSE'S EMPLOYER_____
SPOUSE'S WK PHONE _____
RELATIONSHIP TO PATIENT _____

Whom may we thank for inviting you to our office? _____

In case of an emergency, please contact _____

PRIMARY DENTAL INSURANCE

INSURED'S NAME _____
INSURED'S SOC. SEC. # _____
INSURED'S DATE OF BIRTH_____
INS. COMPANY NAME _____

INS. COMPANY ADDRESS _____
I.D. # _____
GROUP # _____
PHONE # _____

Authorization

I authorize Dr. Garon E. Larsen and/or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agents, including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval. I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal. I understand that as part of the dental treatment, including preventive procedures such as cleaning and preventive dentistry, including fillings of all types, teeth may remain sensitive after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as **Fosamax, Boniva, or Actonel**, may result in complications of non-healing of the jawbones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results for my benefit or the benefit of my minor child. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me. I understand that Dr. Larsen may not be a participating dentist in a discounted insurance plan, and that I am responsible for all charges not paid by the insurance company. I agree to pay a finance charge of 1.5 % per month (an annual rate of 18 %) on the unpaid balance after 90 days and collection costs and/or a reasonable attorney's fee (up to 40% of principal amount owing) if any delinquent balance is placed with an agency or attorney for collection or suit.

Signature: _____ Date: _____
(Patient or legal guardian)

Health History

1. Are you in good health? ☐ Yes ☐ No
2. Has there been any change in your health within the past year? ☐ Yes ☐ No
3. Are you now under the care of a physician? ☐ Yes ☐ No
4. Name and address of physician. _____

5. Have you had any serious illness, operation, or been hospitalized in the past 5 years? ☐ Yes ☐ No
6. Are you taking any medications including non-prescription medications? (list medications) ☐ Yes ☐ No

_____

7. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves or artificial heart valves, including heart murmur? ☐ Yes ☐ No
   b. Cardiovascular disease (heart trouble, heart attack, angina, high blood pressure) ☐ Yes ☐ No
   c. Do you have inborn heart defects? ☐ Yes ☐ No
   d. Do you have a pacemaker? ☐ Yes ☐ No
   e. Have you ever taken Phen-Fen? If so, have you been diagnosed with heart trouble? ☐ Yes ☐ No

f. Allergies (other than seasonal)	☐ Yes ☐ No	s. Stomach ulcer or Hyperacidity	☐ Yes ☐ No
g. Sinus trouble	☐ Yes ☐ No	t. Kidney trouble	☐ Yes ☐ No
h. Asthma	☐ Yes ☐ No	u. Tuberculosis	☐ Yes ☐ No
i. Fainting spells or seizures	☐ Yes ☐ No	v. Persistent or bloody cough	☐ Yes ☐ No
j. Hepatitis, jaundice, or liver disease	☐ Yes ☐ No	w. Persistent swollen glands	☐ Yes ☐ No
k. AIDS or HIV infection	☐ Yes ☐ No	x. Low blood pressure	☐ Yes ☐ No
l. Thyroid problem	☐ Yes ☐ No	y. Sexually transmitted disease	☐ Yes ☐ No
m. Respiratory problems, emphysema	☐ Yes ☐ No	z. Epilepsy, neurological disease	☐ Yes ☐ No
n. Arthritis or painful swollen joint	☐ Yes ☐ No	aa. Problems with mental health	☐ Yes ☐ No
o. Persistent diarrhea or weight loss	☐ Yes ☐ No	bb. Cancer	☐ Yes ☐ No
p. Diabetes	☐ Yes ☐ No	cc. Immune System Problems	☐ Yes ☐ No
q. Abnormal bleeding	☐ Yes ☐ No	dd. Blood transfusion	☐ Yes ☐ No
r. Blood disorder such as anemia	☐ Yes ☐ No	ee. Artificial joints	☐ Yes ☐ No

8. Are you allergic or have you had a reaction to:

☐ Local anesthetics ☐ Penicillin or other antibiotics ☐ Sulfa drugs ☐ Barbiturates or sedatives
☐ Aspirin ☐ Iodine ☐ Codeine or narcotics ☐ Other _____

9. Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ Yes ☐ No

_____

10. Have you ever had any serious trouble associated with any previous dental treatment? _____
11. Are you wearing contact lenses? ☐ Yes ☐ No
12. Are you wearing removable dental appliances? ☐ Yes ☐ No
13. Have you ever used tobacco of any type? ☐ Yes ☐ No
14. Do you use alcoholic beverages? ☐ Yes ☐ No

Women:

15. Are you pregnant? ☐ Yes ☐ No
16. Are you nursing? ☐ Yes ☐ No
17. Are you taking birth control pills? ☐ Yes ☐ No
18. Have you ever taken **Fosamax**, **Boniva**, or **Actonel** for prevention of osteoporosis? ☐ Yes ☐ No

Chief Dental Complaint: _____
If you could change one thing about your smile, what would it be? _____
Do you wish your teeth were whiter? _____
Do you snore or have sleep apnea? _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient _____ Date _____

Signature of Hyg. or Dr. _____ Date _____