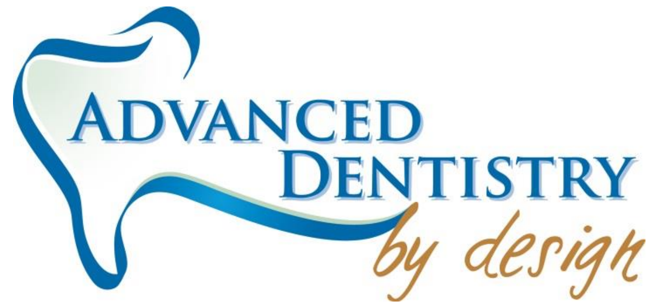

Hi! Just a note to welcome you to the practice; we are looking forward to meeting you!
We will do our best to make your first visit as comfortable and informative as possible.
Please feel free to ask questions at any time regarding your treatment procedures, preventative services, fees or any other aspect 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____

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.

Question	Answer	
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?

Condition		Condition		Condition		Condition	
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:

TruDenta®

HEAD HEALTH HISTORY

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PATIENT INFORMATION

NAME	DATE TODAY / /	AGE ______	SEX ________	TELEPHONE

#	DENTAL FOUNDATION (TEETH, MUSCLES, JOINTS)		
1	Have you noticed a change in the way your teeth fit together? » If 'Yes', it is because of ☐ Dental Changes ☐ Trauma ☐ Other	☐ Yes	☐ No
2	Where do you think your teeth hit or fit first? ☐ More on the right ☐ Left ☐ Equal ☐ More on the front ☐ Back ☐ Equal		
3	Do your jaw muscles get tight or sore? » When? ☐ Morning ☐ Evening ☐ After chewing	☐ Yes	☐ No
4	Do you have pain or difficulty opening wide?	☐ Yes	☐ No
5	Are you aware of noises in your jaw joints? ☐ Popping ☐ Clicking ☐ Other » Where? ☐ Right ☐ Left ☐ Both » How long? ☐ Less than 1 year ☐ More than 1 year	☐ Yes	☐ No
	CAUSES & COMPLICATIONS		
6	Do you grind or clench your teeth? » Do you wear a? ☐ Splint ☐ Night Guard ☐ Retainer	☐ Yes	☐ No
7	Have you had any significant dental treatments? ☐ Orthodontics ☐ Oral surgery / wisdom teeth removal ☐ Long dental appointments ☐ Other	☐ Yes	☐ No
8	Have you been in a car accident, major or minor? » How many? ____________________ » When was the last accident? ☐ 0-6 Months ☐ 6-12 Months ☐ More than 1 year » Did you see the accident coming? ☐ Yes ☐ No » Did the airbag deploy? ☐ Yes ☐ No	☐ Yes	☐ No
9	Have you had sports injuries and/or trauma to your head & neck? » When? ☐ Less than 1 year ☐ More than 1 year	☐ Yes	☐ No
10	Do you work at a desk, computer or in a forward head posture position? » Do you have any other postural position problems? ____________________	☐ Yes	☐ No
11	Daytime sleepiness, drowsiness, or tiredness?	☐ Yes	☐ No
12	Problems with sleep? » Insomnia ☐ Yes ☐ No » Sleep Apnea ☐ Yes ☐ No » Sleep Disturbances ☐ Yes ☐ No » Less than 7 hours per night ☐ Yes ☐ No » Other ____________________		

#	SYMPTOMS
13	Do you experience pain in » Jaw ☐ Right ☐ Left ☐ Both ☐ More than 1 year » Face ☐ Right ☐ Left ☐ Both ☐ More than 1 year » Neck ☐ Right ☐ Left ☐ Both ☐ More than 1 year » Shoulders ☐ Right ☐ Left ☐ Both ☐ More than 1 year » Arms ☐ Right ☐ Left ☐ Both ☐ More than 1 year
14	Do you experience ringing or fullness in your ears? ☐ Yes ☐ No » Which one? ☐ Right ☐ Left ☐ Both
15	How often do you get severe headaches/migraines that makes it difficult to function without treatment or medication? ☐ Occasionally ☐ More than twice a year ☐ More than once a month ☐ More than once a week ☐ Never
16	How often do you get other milder headaches? ☐ Daily ☐ More than 3 per week ☐ More than 2 per month ☐ Other ____________________
17	Have your headaches changed in the last six months? ☐ About the same ☐ Slight worsening ☐ Same but more frequent ☐ A lot worse Got worse when ____________________
	IMPACT ON DAILY LIVING ACTIVITIES
18	What is your stress level? ☐ Mild ☐ Moderate ☐ Severe
19	Do you have anxiety? ☐ Yes ☐ No ☐ Mild ☐ Moderate ☐ Severe
20	Because of pain, headaches or migraines, in the last month: # Of days you could not go to school ______ # Of days you did reduced amount of work ______ # Of days you could not do usual household work/parenting ______ # Of days you missed family or social functions ______
21	When you have pain, headaches or migraines, how does that make you feel? *(Check all that apply)* ☐ Angry ☐ Depressed ☐ Tired or exhausted ☐ Frustrated ☐ Guilty ☐ Ashamed ☐ Relationship tension ☐ Other ____________________
22	How many days per month are you: Pain Free? ____________________ Headache Free? ____________________
	NOTES: ____________________

PHOTOGRAPHY MODEL RELEASE

I, the undersigned, do hereby grant permission to Drs. Euse & Wright to reproduce the photographs taken of me, for the purpose of publication, promotion, illustration, advertising, or trade, in any manner or in any medium.

I do hereby assign absolutely the copyright and/or right to copyright such photographs/videos taken on_____________________, and the right of reproduction thereof for use by Drs. Euse & Wright in the use of patient education, case publishing, practice marketing including print media, website in any manner, including the right of necessary retouching and tinting or work up for reproduction purposes.

I understand that I will receive no payment for posing or for allowing my photographs to be reproduced. I hereby waive any right to approve the finished photograph, or any copy, which might be used in conjunction with the finished photograph.

I acknowledge that I am [ ] over the age of 18
[ ] the legal guardian of the following

If legal guardian of model(s), please list name(s) here:
____

Signature: ____

Date:____