# Common Sense Family Dentistry
## Scott Stucki, D.D.S.

619 S. Bluff Street, Tower 1, 4th Floor St. George, UT 84770 (435) 628-5001

**Patient Information**

Patient Name: _____ Date: _____
Last First MI Preferred

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married Birthdate: _____/_____/_____

Mailing Address: _____ SSN: _____-____-_____

_____
City State Zip

Phone: Home (____) _____-_____ Work (____) _____-_____ Cell (____) _____-_____

Email: _____@ _____. _____ May we send text reminders? ☐ Yes ☐ No

Employer Name: _____ May we call you on your cell phone? ☐ Yes ☐ No

**Emergency Contact** Name: _____ Relationship:_____

Phone Number: (___) ____-_____ Address: _____

**Responsible Party Information**

Name: _____ **Same as Above:** ☐
Last First MI Preferred

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married Birthdate: _____/_____/_____

Mailing Address: _____ SSN: _____-____-_____

_____
City State Zip

Phone: Home (____) _____-_____ Work (____) _____-_____ Cell (____) _____-_____

Employer Name: _____

Is the responsible party a patient of Common Sense Family Dentistry? ☐ Yes ☐ No

**Insurance Information-*all information refers to Insured Member***

Name: _____ Birthdate: _____/____/____

Mailing Address: _____ SSN: _____-____-_____

_____
City State Zip

Phone: Home (____) _____-_____ Work (____) _____-_____ Cell (____) _____-_____

Employer Name: _____

Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Is the insured a patient of Common Sense Family Dentistry? ☐ Yes ☐ No

Insurance Company Name: _____

Insurance Company Phone Number: _____

**How did you hear about our office?** _____

## Insurance Authorization

## Signature on File

1. I authorize the use of this form on all my insurance submissions.
2. I authorize release of niformation to all my insurance carriers.
3. I understand I am responsible for my bill regardless of whether insurance pays or not. All
4. I authorize my doctor to act as my agent in helping me to obtain payment form my insurance carriers. Any amount not paid by my insurance within 60 days of the service date will be paid by me.
5. I authorize payment of claims directly to my doctor.
6. I permit a copy of this authorization to be used in place of the original.

Name _____ Date: _____ Witness:_____
(Please print)

Signature _____

# Consent for Treatment

1. I hereby authorize Dr. Stucki and his associates and staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

2. Upon such diagnosis, I authorize Dr. Stucki and his associates to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives, and other medication necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any complications.

4. I agree to be responsible for payment of all services rendered on my behalf or my that of my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I agree to pay all costs of collection, including a 50% collection fee, attorney fees, court fees and interest at the rate of 1 ½% (18% APR) and any late charges. If required, I also understand a check of my credit history may be made.

Patient's Signature: _____ Date: _____

Parent/Responsible Party Signature: _____Relationship :_____

| Patient Name | MEDICAL HISTORY |
|---|---|
| Patient Account No. | Medical Alert |

1. Physician's Name _____ Phone ( ) _____
   Have you had any medical care within the past two years? ..... Yes No
   Describe _____
2. Have you taken any medication or drugs during the past two years? ..... Yes No
   If yes, please list name and dosage _____
3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? ..... Yes No
   If yes, please list name and dosage _____
4. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other bisphosphonates? ..... Yes No
   If yes, please list name and dosage _____
5. Are you aware of having an allergic **(or adverse)** reaction to any substance or medication? ..... Yes No
   If yes, please specify _____
6. Have you been a patient in the hospital during the past five years? ..... Yes No
7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Heart (Surgery, Disease, Attack) | Yes | No | Ulcers | Yes | No | Hepatitis A B C (circle) | Yes | No |
| Chest Pain | Yes | No | Diabetes | Yes | No | Venereal Disease | Yes | No |
| Congenital Heart Disease | Yes | No | Thyroid Problems | Yes | No | A.I.D.S./H.I.V. Positive | Yes | No |
| Heart Murmur | Yes | No | Glaucoma | Yes | No | Cold Sores/Fever Blisters | Yes | No |
| High/Low Blood Pressure | Yes | No | Contact lenses | Yes | No | Blood Transfusion | Yes | No |
| Mitral Valve Prolapse | Yes | No | Emphysema | Yes | No | Hemophilia | Yes | No |
| Artificial Heart Valve/Pacemaker | Yes | No | Chronic Cough | Yes | No | Sickle Cell Disease | Yes | No |
| Rheumatic Fever | Yes | No | Tuberculosis | Yes | No | Bruise Easily | Yes | No |
| Arthritis/Rheumatism | Yes | No | Asthma | Yes | No | Liver Disease/Yellow Jaundice | Yes | No |
| Cortisone Medicine | Yes | No | Hay Fever/Allergy/Hives | Yes | No | Neurological Disorders | Yes | No |
| Swollen Ankles | Yes | No | Latex Sensitivity | Yes | No | Epilepsy or Seizures | Yes | No |
| Stroke | Yes | No | Sinus Trouble | Yes | No | Fainting or Dizzy Spells | Yes | No |
| Diet (Special/Restricted) | Yes | No | Radiation Therapy | Yes | No | Nervous/Anxious | Yes | No |
| Artificial Joints (hip, knee, etc.) | Yes | No | Chemotherapy | Yes | No | Psychiatric/Psychological Care | Yes | No |
| Kidney Trouble | Yes | No | Tumors | Yes | No | Cancer | Yes | No |

8. Have you lost or gained more than 10 pounds in the past year? ..... Yes No
9. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No
   If yes, please list: _____
10. **Women:** Are you pregnant or think you could be pregnant? Yes _____ Months No **Nursing?** Yes No
11. Do you use birth control prescriptions? ..... Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

**History Review**

Dentist Signature _____ Date _____

| Patient Name | |
|---|---|
| Patient Account No. | Medical Alert |

# DENTAL HISTORY

*Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.*

What is the reason for your visit today? _____

_____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____ Telephone _____

Address _____ State _____ Zip _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

Have you ever used or are currently using topical fluoride? Yes No

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No If yes, please describe: _____

Are any of your teeth sensitive to:

| | | |
|---|---|---|
| Hot or cold? | Yes | No |
| Sweets? | Yes | No |
| Biting or Chewing? | Yes | No |
| Have you noticed any mouth odors or bad tastes? | Yes | No |
| Do you frequently get cold sores, blisters or any other oral lesions? | Yes | No |
| Do your gums bleed or hurt? | Yes | No |
| Have your parents experienced gum disease or tooth loss? | Yes | No |
| Have you noticed any loose teeth or change in your bite? | Yes | No |
| Does food tend to become caught in between your teeth? | Yes | No |

If yes, where _____

Do you:

| | | |
|---|---|---|
| Clench or grind your teeth while awake or asleep? | Yes | No |
| Bite your lips or cheeks regularly? | Yes | No |
| Hold foreign objects with your teeth? (pencils, pipe, etc.) | Yes | No |
| Mouth breathe while awake or asleep? | Yes | No |
| Have tired jaws, especially in the morning? | Yes | No |
| Snore or have any other sleeping disorders? | Yes | No |
| Smoke/chew tobacco or use other tobacco products? | Yes | No |

Have you ever had:

| | | |
|---|---|---|
| Orthodontic treatment? | Yes | No |
| Oral Surgery? | Yes | No |
| Periodontal treatment? | Yes | No |
| Your teeth ground or the bite adjusted? | Yes | No |
| A bite plate or mouth guard? | Yes | No |
| A serious injury to the mouth or head? | Yes | No |

Please describe, including cause _____

Have you experienced:

| | | |
|---|---|---|
| Clicking or popping of the jaw? | Yes | No |
| Pain? (joint, ear, side of face) | Yes | No |
| Difficulty in opening or closing the mouth? | Yes | No |
| Difficulty in chewing on either side of the mouth? | Yes | No |
| Headaches, neckaches or shoulder aches? | Yes | No |
| Sore muscles (neck, shoulders)? | Yes | No |
| **Are you satisfied with your teeth's appearance?** | Yes | No |
| Would you like to replace your silver fillings? | Yes | No |
| Would you like to keep all of your teeth all of your life? | Yes | No |

| | | |
|---|---|---|
| Do you feel nervous about having dental treatment? | Yes | No |
| Please describe _____ | | |
| Have you ever had an upsetting dental experience? | Yes | No |
| Please describe _____ | | |
| Have you ever been told to take a pre-medication prior to dental treatment? | Yes | No |
| Is there anything else about having dental treatment that you would like us to know? | Yes | No |

If yes, please describe _____

_____

(Please complete other side)

# Doctor's Painless Pledge

***I pledge to dedicate myself to using the best techniques and technologies in my possession to Painlessly perform your dental treatment where ever possible.***

Welcome to the world of Painless Dentistry. Painless Dentistry by definition is delivering an injection in such a manner that it reduces or eliminates pain. The method in which dental procedures are performed should reduce both anxiety and pain during and after treatment. While not every procedure can be painless our office is dedicated to providing Painless Dentistry to the best of our abilities through proven techniques and available technology to reduce pain for the majority of dental procedures.

Many people interpret pressure or vibration as pain, this is a common misconception. Your dental team will explain what you can expect both during and after your dental procedure to help relieve any stress or anxiety in regard to your treatment.

This form is presented to every patient that Dr. Stucki sees to insure that they understand his commitment to providing treatment in an environment that is as Painless as possible. Each patient is encouraged to confer with the doctor or a team member to gain a more thorough understanding of each procedure before it is performed.

The American Academy of Painless Dentistry has collected documentation that Dr. Stucki has been able to perform Painless Dentistry for other patients. We trust he will be able to provide you with a similar experience.

We encourage you to let us know of your Painless experience by sending us a letter or an e-mail to the American Academy of Painless Dentistry to help us further document his Painless performance.

**Mailing Address**
**American Academy of Painless Dentistry**
473 South River Road, Suite 1-511
St. George, UT 84790

**E-mail Address**
smile@drpainless.org

Patient Signature:_____ Date: _____

common sense FAMILY DENTISTRY.com
Dr. Scott Stucki
(435) 628-5001

# *Medical Information Form*
# *(HIPAA Release Form)*

Name: _____ Date of Birth: _____/_____/_____

## *Release of Information*

I authorize the release of information including the diagnosis, records, examination(s) rendered to me and claims information. This information may be released to:

☐ Spouse _____

☐ Child(ren) _____

☐ Other _____

☐ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

## *MESSAGES*

Please call: ☐ My Home ☐ My Work ☐ My Cell Number _____

If unable to reach me:

☐ You may leave a detailed message
☐ Please leave a message asking me to return your call
☐_____

The best time to reach me is: _____(day) between _____(Time)

Signed: _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____