Patient Information NVDG

Skip Form

First Name *

Last Name *

MI

Preferred Name

Title

Gender *

Family Status *

Birthday *

/ /

MM DD YYYY

SSN *

Drivers license

Address *

Street Address

Address Line 2 (Apartment number, Suite number, or Room number)

Select a State/Province

City

State / Province / Region

United States

Postal / Zip Code

Country

Home Phone *

- -

Work Phone

- -

Mobile Phone *

- -

Email *

Referred By

Student Status

School Name

Employment Status *

Appointment Preference

Communication Preferences

☐ I receive emails

☐ I receive mobile text

Draw your signature into the box below. *

Clear

Relationship to the patient *

Name if not the patient *

Continue

Dental History

Skip Form

Patient First name *

Patient Last Name *

Why you are changing dentist?

- ☐ Change of residence
- ☐ Change of dental plan
- ☐ Your office is closer
- ☐ My dentist retired/closed
- ☐ Unhappy
- ☐ Too expensive
- ☐ You were recommended
- ☐ Other

Please explain

How long since the last visit to dentist? *

- ☐ 1 month
- ☐ 3 months
- ☐ 6 months
- ☐ 1 year
- ☐ 2 years
- ☐ 3 or more years
- ☐ I've never seen a dentist

How did you find us? *

- ○ Other Patient
- ○ Dental Office
- ○ Yelp Google
- ○ Internet
- ○ Yellow Pages
- ○ Mailer
- ○ Work
- ○ School
- ○ Insurance Company
- ○ Other

Reason for the visit *

- ☐ Check-up
- ☐ Cleaning

☐ Pain ☐ Other

Please provide details

Have you ever had a bad experience at the dentist *

◯ No ◯ Yes

If yes please explain

Have you had any complications following dental treatment? *

◯ No ◯ Yes

If yes please explain

Have you had unfavorable reaction to dental anesthetic? *

◯ No ◯ Yes

If yes please explain

Does dental treatment make you nervous? *

◯ No ◯ Yes, Slightly

◯ Yes, Moderately ◯ Yes, Extremely

Are your teeth sensitive to cold, hot? *

◯ No ◯ Yes

Do your gums bleed when you brush or floss? *

◯ No ◯ Yes

Do you grind your teeth? *

◯ No ◯ Yes

Are you aware of sores or irritated areas in the mouth? *

◯ No ◯ Yes

Have you ever been treated for Periodontal Disease? *

No Yes

How often do you brush? *

- Once a day
- Twice a day
- Three times a day
- Every time I eat

How often do you floss? *

- Never
- Occasionally
- Once a day
- Twice a day
- Three times a day
- Every time I eat

Do you like your smile? *

No Yes

If you could change your smile, what would you like to change?

- The color of my teeth
- Close spaces or restore worn and broken teeth
- The shape of my teeth
- The position or alignment of my teeth
- Other

If Other please specify

I am interested in *

- Teeth whitening
- Cosmetic evaluation
- Replacement of missing teeth
- Straight teeth
- Sedation
- White fillings
- Home care
- Breath control
- Other

If Other please specify

To ensure your visit is a great experience, please share any questions or concerns you would like us to know about

Continue

Eaglesoft Medical History

Skip Form

Patient First Name

Patient Last Name

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

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble

- [ ] Spina Bifida
- [ ] Stomach/Intestinal Disease
- [ ] Stroke
- [ ] Swelling of Limbs
- [ ] Thyroid Disease
- [ ] Tonsillitis
- [ ] Tuberculosis
- [ ] Tumors or Growths
- [ ] Ulcers
- [ ] Venereal Disease
- [ ] Yellow Jaundice

Have you ever had any serious illness not listed above? *

○ No ○ Yes

Are you under a physician's care now? *

○ No ○ Yes

Have you ever been hospitalized or had a major operation? *

○ No ○ Yes

Have you ever had a serious head or neck injury? *

○ No ○ Yes

Are you taking any medications, pills, or drugs? *

○ No ○ Yes

Do you take, or have you taken, Phen-Fen or Redux? *

○ No ○ Yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? *

○ No ○ Yes

Are you on a special diet? *

○ No ○ Yes

Do you use tobacco? *

○ No ○ Yes

Do you use controlled substances? *

○ No ○ Yes

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

Other? *

○ No ○ Yes

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.

Draw your signature into the box below. *

Clear

Relationship to the patient *

Name if not the patient *

Continue

Screening Questionnaire

Skip Form

Patient First Name *

Patient Last Name *

COVID-19 Screening Questionnaire

In following both CDC and ADA recommendations, this questionnaire is designed with your safety in mind. Please complete the questionnaire no more than 24 hours prior to your scheduled dental appointment.Your answers will be reviewed prior to your appointment and a member of our team will contact you if we recommend rescheduling to a later date. Thank you for your help in keeping our staff and patients safe.

Do you have a fever and/or have had a fever recently (last 14-21 days)? *

◯ No ◯ Yes

Have you ever tested positive for COVID-19? *

◯ No ◯ Yes

Are you in contact with any confrmed COVID-19 positive patients? (Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment. *

◯ No ◯ Yes

Are you having shortness of breath or any difficulty breathing? *

◯ No ◯ Yes

Do you currently have a cough or sore throat? *

◯ No ◯ Yes

Hve you experienced loss of taste or smell? *

◯ No ◯ Yes

Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location) *

○ No ○ Yes

Is there anything else our team should know before treating you?

Draw your signature into the box below.

Clear

Relationship to the patient

Name if not the patient

Continue

Patient Dentist Arbitration Agreement

Skip Form

Patient-Dentist Arbiration Agreement

Article I.

It is understood that any dispute as to dental malpractice, this, as to whether any dental services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, would be determined by submission to arbitration as provided by California Law, and not by a lawsuit, or resort to court process, except as California law provides for judicial review or arbitration proceedings. Both parties of this contract by entering into it, have given up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Treatment in this office is contingent upon both parties consenting to this Arbitration Agreement.

Article II.

A. Parties to the Agreement:
The term "patient" as used in this agreement includes the undersigned individual, his or her spouse, children (whether born or unborn), and heirs, assigns or personal representatives. The individual signing this Agreement signs it on behalf of the foregoing persons, and intends to bind each of them to arbitration to the full extent permitted by law.

The term "doctor" as used in this agreement includes the undersigned doctor and his or her professional corporation or partnership, and any employees, agents, successors in interest, heirs and assigns of the foregoing individuals or entities and independent contractors. The doctor signing this agreement signs it on behalf of all the foregoing individual and entities, and intends to bind each of them to arbitration to full extent permitted by law.

B. Treatment Covered:
Patient understands and agrees that any dispute of the sort descried in Article I between doctor and patient will be subject to compulsory, binding arbitration.

C. Coverage of Pre-Natal Claims (If Applicable):

Patient understands and agrees that, if doctor treats her during pregnancy, any dispute or sort descried in Article I as to dental treatment rendered to or affecting the unborn child will be subject to compulsory, binding arbitration.

Article III.

A. Informal Resolution of Disputes:
In the event patient feels that a problem has arisen in connection with the dental care rendered by doctor to patient, patient will promptly notify doctor so that doctor may have the opportunity to resolve the matter. Notice may be given orally or in writing, and shall stop the running or statute of limitations for ninety (90) days.

B. Method of Initiating Arbitration:
If the dispute is not resolved by mutual Agreement within ninety (90) days, patient may initiate arbitration by notifying doctor to that affect. The arbitrator shall be selected by the chief administrator of JAMS ENDISPUTE. The arbitrator must be selected within twenty-one (21) days of the signature on the receipt for a letter sent certified mail return receipt request demanding that a dispute submitted to arbitration. Following the selection of the arbitrator, arbitration must be held within thirty (30) days.

C. Applicable Law:
The arbitration shall be conducted pursuant the California Arbitration Act (C.C.P. 1280-1296). The Arbitrator shall, in addition, have authority to order such other discovery as he/she deemed appropriate for a full and fair hearing of the case. A determination on the merits shall be rendered in accordance with the law of the State of California, including the provisions of the Medical Injury Compensation Reform Act 1975 which shall apply to the same extent as if to dispute or pending before a Superior Court of the State of California.

The arbitrator shall not have the power to commit errors of law or legal reasoning, and the arbitrator's decision may be vacated or corrected pursuant the California Code of Civil Procedure Sections 12806.2 or 12086.6 for any such error.

The prevailing party shall be entitled to attorney fees.

Article IV.

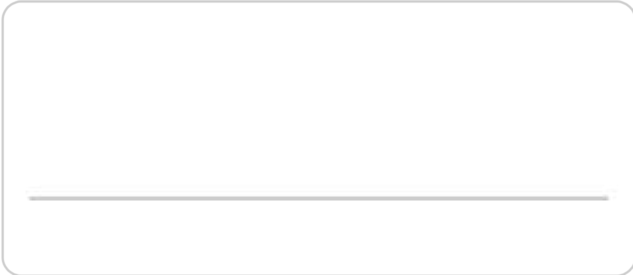
A. Revocation:
If you are signing this agreement and then change your mind, the law permits you to revoke the Agreement providing you give your doctor written notice within thirty (30) days of signing that you want to withdraw from the Agreement. However, doctor and patient agree that any claim arising for dental services rendered prior to revocation shall be subjected to arbitration. Furthermore, doctor is not obligated to continue the doctor/patient relationship should you decide to withdraw from the agreement.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF DENTAL MALPRACTICE DECIDED BY MUTUAL ARBITRATION AND YOU ARE GIVING UP RIGHT TO JURY OR COURT TRIAL, SEE ARTICLE I OF THIS CONTRACT.

Patient First Name *

Patient Last Name *

Draw your signature into the box below. *



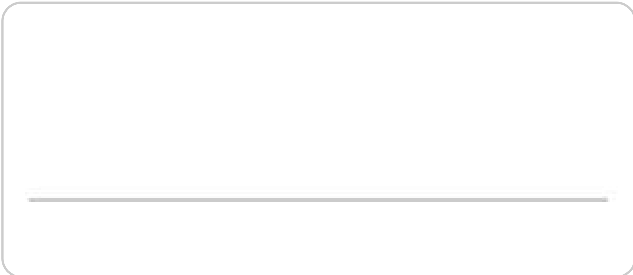
Clear

Relationship to the patient *

Name if not the patient *

Witness Signature

Draw your signature into the box below.



Clear

Date

/ /

MM DD YYYY

Continue

HIPAA Acknowledgement Form

Skip Form

Patient First Name *

Patient Last Name *

Relationship to the patient *

Name if not the patient *

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

-Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly

-Obtain payment from designated third-party payers.

-Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

I have been informed by you of your Notice of Privacy Practices that contains a more complete description of the uses and disclosures of my health information (available at the following link HIPAA Notice of Privacy Practices or in office in print form).

I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that Napa Valley Dental Group has the right to change its Notice of Privacy Practices from time to time and that I may contact Napa Valley Dental Group at any time to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that Napa Valley Dental Group restricts how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand Napa Valley Dental Group is not required to agree to my requested restrictions, but if Napa Valley Dental Group does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that Napa Valley Dental Group has taken action relying on this consent.

By checking the box I acknowledge that *

☐ I received and read this organization Notice of Privacy Practices

Please sign *

Clear

Continue

GENERAL DENTISTRY INFORMED CONSENT

Skip Form

Patient First Name *

Patient Last Name *

EXAMINATION AND X-RAYS

I understand that the initial visit may require radio-graphs in order to complete the examination, diagnosis, and treatment plan. If needed for future evaluation CT-scan can be performed for proper diagnosis.

DRUGS, MEDICATION, AND SEDATION

I have been informed and understand that antibiotic, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand that and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic medication and drugs that may have been given me in the office for my treatment. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain, and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

CHANGES IN TREATMENT PLAN

I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any or all changes and additions as necessary.

TEMPOROMANDIBULAR JOINT DYSFUNCTIONS (TMJ)

I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility.

FILLINGS

I understand that care must be exercised in chewing on filling during the first 24 hours to avoid breakage, and tooth sensitivity is common after-effect of a newly placed filling.

REMOVAL OF TEETH (EXTRACTION)

I understand removing teeth does not always remove all infection if present and it may be necessary to have further treatment. I understand the risks involved is having teeth removed, some of which are pain, swelling, and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (parathesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

CROWNS, BRIDGES, VENEERS AND BONDING

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realized that the final opportunity to make changes in my new crowns, bridge or cap (including shape, fit, size, placement, and color) will be done before cementation. It has been explained to me that, in very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures.

DENTURES COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal and or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not the initial denture fee.

ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth and those complications can occur from the treatment and that occasionally metal objects are cemented in the tooth, or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy) on re-treatment of root canal.

PERIODONTAL TREATMENT

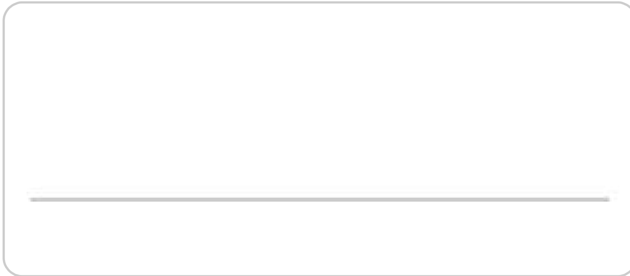
I understand that I have a serious condition causing gum inflammation and/or bone loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery and/or extractions. I understand the success of a treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, following a healthy diet, avoid tobacco products and follow other recommendations.

I understand that every reasonable effort will be made to ensure that my condition is treated properly, although it's not possible to guarantee perfect results. By signing below, I acknowledge that I have received adequate information about the proposed treatment, that I understand this information and that all of my questions have been answered to my satisfaction.

I had the opportunity to discuss any alternatives to this treatment with my dentist. All of my questions were answered to my satisfaction regarding such alternatives and their risks, benefits, and costs.

No guarantee or assurance has been given to me by anyone that the proposed treatment or surgery will cure or improve the condition(s) listed above.

Draw your signature into the box below. *



Clear

Continue

Cancellation Missed Appointment Policy for Procedures

Skip Form

Cancellation/Missed Appointment Policy for Procedures

Patient First Name *

Patient Last Name *

We have reserved a specific time for you with our providers. If you cannot keep your scheduled appointment, please be sure to notify us within 48 business hours, so that we may offer your reserved time to another patient. If we are not given ample notification for a cancellation or you fail to make it to your appointment, you are subject to a $50 fee for preventative appointments and $150 fee for Doctor's restorative appointments.

Acknowledge of Receipt

Please Read and Acknowledge by checking the box *

☐ I acknowledge that I have read and understand Napa Valley Dental Group's cancellation and/or missed procedure policy.

Draw your signature into the box below. *

Clear

Relationship to the patient *

Name if not the patient *

Continue