ARCH
DENTAL

# Our Three Commitments to You

These commitments are put into writing because we believe that they are critical for the success of our patients in our practice. These may be different from what you have experienced in other offices, but the trust that is critical to our working together is built upon these three foundations.

***Commitment to Treatment***

We believe that dental disease is almost completely preventable. If treatment is begun, we believe it should be completed and the work we provide must be taken care of to the best of your ability. If work is not completed the likelihood of additional complications, and extra expenses and potential tooth loss increases dramatically. These outcomes can also make communication between you and our practice more difficult. We understand that you want as little dental work done during your life as possible; that is our goal for you as well. Following through with your identified treatment needs is the best way to accomplish that goal.

***Commitment to Appointment***

We will reserve time especially for you in our schedule. During this time we will give you our undivided attention, exceptional care and rarely keep you waiting. An appointment at our office is a bond that we will be prepared to serve you in a timely manner.

***Commitment to Financial Considerations***

We will use our skills, professional judgment and compassionate care to help you achieve your optimum level of dental health. Following through with your financial arrangements with our office will allow us to work together with clear expectations and without resentments.

Signature_____Date_____

321 4th Street, North Fargo, ND 58102 P: 701.235.6075 F: 701.239.0140
W: archdentalfargo.com E: info@archdentalfargo.com

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# Registration Form

Please fill out accurately and completely. The confidential information requested is important for your treatment and insurance claim.

## PATIENT INFORMATION

Patient Name: _____Gender: _____ Date of Birth:_____

Home Address: _____a_____

Mailing Address: _____

Em mail Address: _____

Phone: Home: _____Cell: _____Work: _____

Employed by: _____Occupation: _____

Social Security Number: _____(need only if used for insurance ID)

Dental Insurance: _____ID# _____

Subscriber Name: _____DOB: _____

Secondary Dental Ins. _____Subscriber Name: _____

How were you referred to our office? _____

SPOUSE INFORMATION

Spouse Name: _____DOB: _____

Employed by: _____Occupation: _____

Phone: Cell: _____Work:_____

Other information:

_____

_____

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# Patient Questionnaire

Name_____Date_____

Our practice is committed to providing each of our patients with individualized care consistent with their specific needs, wants and values. By answering the following questions candidly, you will help us to better understand your dental concerns and expectations. You answers are for our records only and will remain confidential.

1. Does dental treatment make you nervous? No Slightly Moderately Extremely
2. Have you ever had any serious trouble associated with previous dentistry? Yes No
3. How often do you use the following?
   - Toothbrush (manual or electric) _____
   - Dental floss _____
   - Other oral hygiene device _____

4. Do you have or have you ever had any of the following?

| | | | | | |
|---|---|---|---|---|---|
| Orthodontic treatment | Yes | No | Loose teeth | Yes | No |
| Clicking/popping jaw | Yes | No | Teeth sensitive to hot, cold, sweets | Yes | No |
| Difficulty opening / closing jaw | Yes | No | Teeth sensitive to chewing | Yes | No |
| Clenching or grinding | Yes | No | Bleeding or sore gums | Yes | No |
| Shifting or change in bit | Yes | No | Unpleasant taste or bad breath | Yes | No |

5. The following best describes my attitude toward dental health:
   - I have always done what was recommended for my dental health.
   - I have not always done what dentists have recommended to me.
   - I rarely go to the dentist, not much interest in dental work.

6. Should I need treatment, my desire would be best described as:
   Wanting the best restorations possible that will be the most conservative and give the longest life.
   Wanting the least expensive restoration that will get me by for now.

7. Do you like the color of your teeth? Yes No
8. Do you consider your existing fillings or dental work as unattractive? Yes No
9. What would you like to change most in the appearance of your teeth or your smile?
   _____
10. What are some questions about dentistry and your oral health that you have never had adequately answered?

    _____

    _____

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## There are FOUR LEVELS of CARE that patients seek from our office.

We encourage you to read through these descriptions and decide which one best describes how you currently think about your oral health. Please keep in mind that many of our patients enter our practice at one level but over time move to a higher level.

**Check the box that applies:**

☐ **Reactive**
You prefer to only address issues in your mouth when there is a problem you can feel or that is painful.

☐ **Proactive**
You prefer to maintain regular cleanings and checkups and want to be involved with your health to avoid major issues. You usually prefer to repair areas of concern rather than addressing the underlying issues.

☐ **The Planner**
You want everything the Proactive patient wants and you want to have a Master plan to restore your dental health rather than just repairing damage. You want to treat the causes of your dental disease, not just the effects. You want all treatment provided to be the most predictable and long lasting possible.

☐ **I Want It All**
You want everything The Planner wants and to be seen as having an exceptional smile. A smile that is a perfect fit for you, your face and your personality. You know your smile is the first thing others notice about you and you always want to put your best foot forward. You wonder how modern dentistry can change your smile or even make you look younger.

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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

| | | |
|---|---|---|
| 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

Other? ☐ If yes

Do you use controlled substances? ○ Yes ○ No If yes

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

| | | | |
|---|---|---|---|
| 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:_____

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# Financial Options

We appreciate the trust you have placed in us and would like to that you for choosing our practice for your upcoming dental work. We believe dental treatment is one of the best investments you can make for both your physical and psychological well being. Our intention is to simplify your financial considerations and prevent them from being an obstacle to obtaining this care. We request that payment arrangements be made prior to beginning your treatment. Being sensitive to the different needs people have in fulfilling their financial obligations, we gladly provide you with several payment options.

**Payment in Full**
Payment is made prior to the start of any treatment by cash, check, Visa, MasterCard, American Express or Discover by the first appointment. The one-time payment would be $_____.

**Two Payments**
For cases involving lab work, crowns, bridges, implant crowns, dentures, splints, etc. one-half may be made when the work is started (when impressions are taken) and the second-half made on or before the day the work is completed.
The first half payment in the amount of $_____, and the second half payment in the amount of $_____to be paid by cash, check, Visa, MasterCard, American Express or Discover.

**Custom Payment schedule**
I agree to pay Arch Dental the treatment fee in the following manner:_____
_____
_____
_____
_____

**CareCredit**
A credit card for health care costs, interest free payment plans up to 12 months with payments as low as $_____. Interest retroactive at ____% if a payment is missed or not paid in full within the interest free period. Applications available in the office or apply online at www.carecredit.com.

Please be aware that clinical findings may require a change in treatment plan, with a possible change to your cost. The total fee is the patient's personal obligation. Please select your preferred payment opton, sign below and return to us for our records.

Printed Name:_____
Signature: _____Date:_____

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