



2815 Grand Prairie Pkwy, Suite 3  
Waukee, IA 50263  
Ph: 515-500-1946  
Fax: 515-500-1947

## Appointment Conditions

Our part in our relationship is to help you complete your treatment goals. Your part in our relationship is to make sure to keep your appointments. We are asking for your assistance and understanding of our cancellation conditions.

We require a 24 hour notice if you are needing to change or cancel any scheduled appointment. If you are not able to give us a 24 hour notice, a fee will occur from your missed appointment.

If your appointment is for restorative work, you will forfeit 10% of the scheduled treatment. Upon rescheduling your appointment, you will owe the 10% that was forfeited upon missing the previous appointment.

If you are 15 minutes late for your appointment you may be asked to reschedule or we may be required to shorten the length of the planned treatment.

We are happy to assist in rescheduling your appointment by calling the office at: (515) 500-1946

**I acknowledge I have read the above terms and conditions.**

**X** \_\_\_\_\_ **Date:** \_\_\_\_\_



## Dental History

Please answer the following dental questions for yourself, or on behalf of your dependent if you are not the patient receiving care.

**Previous/ Present Dentist and Date of last dental visit:**

---

**Please answer the following dental questions for yourself:**

How important is your dental health to you on a scale from 1-10?

Where would you rate your dental health on a scale from 1-10?

How confident are you in your smile on a scale from 1-10?

What is the most important thing to you about your future dental health? \_\_\_\_\_

---

What is your main concern for today's dental visit? \_\_\_\_\_

---

**If you could change your smile, would you? Please circle any that apply:**

Make them whiter   Close spaces   Repair chipped teeth   Have a smile makeover

Make them straighter   Replace black metal fillings with natural tooth colored fillings

Replace missing teeth   Replace old crowns that do not match

Other: \_\_\_\_\_

---

---



**Which of the following oral conditions have you experienced since your last dental visit? Please circle any that apply:**

Sensitivity (cold, heat, sweets, biting)    Excessive gagging    Teeth or fillings breaking

Dry mouth or mouth breathing    Tooth pain or discomfort    Bad breath

Cracked or chipped teeth    Food collection between teeth

Chewing on one side of the mouth    Burning sensation on tongue

TMJ (Jaw pain, clicking or popping)    Blisters/sores on lips or mouth

Bleeding, swollen or irritated gums    Injury to teeth, mouth, or jaws    Loose or shifting teeth

**How often do you brush per day?** 1x    2x    3x    weekly    never

**How often do you floss per day?** 1x    2x    3x    weekly    never

**Do you use a waterpik?** Yes No

**Have you ever had orthodontic treatment (braces, spacers, or other appliances)?** Yes No

**If you currently have a partial or denture would you be interested in learning about a permanent and more comfortable solution?** Yes No

**Do you have any fears of dental visits?** \_\_\_\_\_

\_\_\_\_\_

**Do you have an upcoming event where you are wanting to show your new smile to the world?** Yes No

**Is there anything else you would like us to know?** \_\_\_\_\_

\_\_\_\_\_



2815 Grand Prairie Pkwy, Suite 3  
Waukee, IA 50263  
Ph: 515-500-1946  
Fax: 515-500-1947

## HIPAA Compliance Patient Consent Form

Our notice of privacy practices provides information about how we use or disclose protected health information.

The notice contains a patient's right section describing your rights under the law. You ascertain that by signature that you have reviewed our notice of privacy practices.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare options. We are not required to agree with the restriction, but if we do, we shall honor this agreement. The HIPAA law allows for the use of the information for treatment, payment, or healthcare options.

**By signing this form, I understand that:**

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke the consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

**If you would like us to discuss your treatment with any member of your family, please list them and their relationship to you below. If you do not want to share your information with any other party, please leave the information blank and sign below.**

**Individual you would like any relevant health information shared with:**

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**I attest that the above information is correct.**

**X** \_\_\_\_\_ **Date:** \_\_\_\_\_



2815 Grand Prairie Pkwy, Suite 3  
Waukee, IA 50263  
Ph: 515-500-1946  
Fax: 515-500-1947

## Photo Release

I, \_\_\_\_\_ hereby give **Express Dental Studio** and its successors and assigns and those accruing under its permission or upon its authority, the unqualified right and permission to reproduce, copyright, publish, circulate or otherwise use my name and my photographs. I understand that my photographs may be edited for clarity and /or conciseness. I waive any right to inspect and approve the finished product or copy that may be used or the use to which it may be applied. This authorization and release covers the use of said materials in any published, broadcast or electronic form, any medium of advertising, publicity or trade in any part of the world for an indefinite period of time.

I also give **Express Dental Studio** the unqualified right and permission to film my appointment for reference and training materials for team members to learn from.

I waive any right to inspect and approve the finished product or copy that may be used or the use to which it may be applied. This authorization and release covers the use of said materials for training materials.

Furthermore, for the consideration above mentioned, I, myself, my heirs, executors, administrators, or assigns, transfer to the organization, its successors and assigns, all my rights mentioned above to all representatives of the organization. This agreement represents in full all terms and considerations, and no other inducements, statements, or promises have been made to me.

X \_\_\_\_\_ Date: \_\_\_\_\_



2815 Grand Prairie Pkwy, Suite 3  
Waukee, IA 50263  
Ph: 515-500-1946  
Fax: 515-500-1947

## Financial Guideline

Thank you for choosing our office as your dental health care provider. At Express Dental Studio we are committed to providing you with the best possible dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment. In order to achieve these goals, we need your assistance and understanding of our payment policy.

Payment is due upon scheduling treatment. We accept payments by cash, check or credit card (Mastercard, Visa, American Express and Discover). Outside financing is available upon request and approval (Cherry, Lending Club and iCredit Works). All card transactions have an additional 3% charge.

If you have dental insurance, we will help you receive your maximum allowable benefits. We will gladly assist you by delivering all information, codes, radiographs, photos and notes pertaining to charges for care rendered in our office. With this information, you will be able to file claims with your insurance company on your behalf. We will gladly discuss your proposed treatment.

### **However, please realize:**

Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. There is no guarantee of benefits and your insurance carrier may deny payment for any reason. Insurance companies have the liberty to change your benefit structure at any given time without notifying our office or you. Having dental insurance does not guarantee payment.

We must emphasize that as a dental care provider, our relationship is with you, our patient and your family and not with your insurance company. All charges for treatment are your responsibility from the date the services are rendered.

I acknowledge I have read, understand and agree to the above terms and conditions.

X \_\_\_\_\_ Date: \_\_\_\_\_

## Medical History

Please answer the following medical questions for yourself, or on behalf of your dependent if you are not the patient receiving care.

**Do you require any antibiotics or other medication prior to dental treatment? Yes No**

Are you currently under the care of a physician? Yes No

Have you ever been hospitalized or had a major operation? Yes No

Have you ever had a serious head or neck injury? Yes No

**Are you taking any medications? Yes No**

Do you take, or have you taken, Phen-Fen or Redux? Yes No

**Have you ever taken Fosamax, Prolia, Alendronate, Zolendronate, Zoledronic Acid, Reclast, Boniva, Actonel, Risedronate, Zometa, Ibandronate, or any other medications containing Bisphosphonates? Yes No**

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Have you ever had Botox/Dermafiller? Yes No

Do you suffer from headaches or migraines? Yes No

Do you grind or clench your teeth? Yes No

Do you sleep with a CPAP? Yes No

**Are you allergic to any of the following?**

**Acrylic, Local Anesthetics, Aspirin, Metal, Codeine, Penicillin, Latex, Sulfa Drugs, Other** \_\_\_\_\_

If you said yes to any of the above, please provide a brief explanation of your reaction.

---

---

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

AIDS/HIV Positive: Yes No

Alzheimer's Disease: Yes No

Anaphylaxis: Yes No

Anemia: Yes No

Angina: Yes No

Anxiety: Yes No

Arthritis/Gout: Yes No

Artificial heart valves: Yes No

Artificial joints: Yes No

Asperger Syndrome: Yes No



2815 Grand Prairie Pkwy, Suite 3  
Waukee, IA 50263  
Ph: 515-500-1946  
Fax: 515-500-1947

Asthma: Yes No  
Autism Spectrum Disorder or sensory integration disorder: Yes No  
Bladder issues: Yes No  
Blood disease: Yes No  
Blood transfusion: Yes No  
Breathing problems: Yes No  
Bruise easily: Yes No  
Cancer: Yes No  
Cerebral Palsy: Yes No  
Chemotherapy: Yes No  
Chest pains: Yes No  
Cold Sores/Fever Blist: Yes Noers  
Congenital heart disease: Yes No  
Convulsions: Yes No  
Cortisone medicine: Yes No  
Depression: Yes No  
Diabetes: Yes No  
Drug Addiction: Yes No  
Easily winded: Yes No  
Emphysema: Yes No  
Epilepsy or seizures: Yes No  
Excessive bleeding: Yes No  
Excessive thirst: Yes No  
Fainting spells/dizziness: Yes No  
Frequent cough: Yes No  
Frequent diarrhea: Yes No  
Gastroesophageal/Acid Reflux (GERD): Yes No  
Genital herpes: Yes No  
Glaucoma: Yes No  
Hay fever: Yes No  
Heart attack/failure: Yes No  
Heart murmur: Yes No  
Heart pace maker: Yes No  
Heart Trouble/Disease: Yes No  
Hemophilia: Yes No  
Hepatitis: A Yes No  
Hepatitis: B or C Yes No  
Herpes: Yes No  
High blood pressure: Yes No  
High Cholesterol: Yes No



2815 Grand Prairie Pkwy, Suite 3  
Waukee, IA 50263  
Ph: 515-500-1946  
Fax: 515-500-1947

Hives or Rash: Yes No  
Hypoglycemia: Yes No  
Immune Deficiency (Any): Yes No  
Irregular Heartbeat: Yes No  
Kidney problems/disease: Yes No  
Leukemia: Yes No  
Liver Disease: Yes No  
Low blood pressure: Yes No  
Lung Disease: Yes No  
Mitral valve prolapse: Yes No  
Osteopenia: Yes No  
Osteoporosis: Yes No  
Pain in Jaw Joints: Yes No  
Parathyroid disease: Yes No  
Psychiatric Care: Yes No  
Radiation Treatments: Yes No  
Recent weight loss: Yes No  
Renal dialysis: Yes No  
Respiratory disease: Yes No  
Rheumatic fever: Yes No  
Rheumatism: Yes No  
Scarlet fever: Yes No  
Sexually Transmitted Infections: Yes No  
Shingles: Yes No  
Shortness of breath: Yes No  
Sickle cell disease: Yes No  
Sinus trouble: Yes No  
Sleep apnea: Yes No  
Spina bifida: Yes No  
Stomach/Intestinal Disease: Yes No  
Stroke: Yes No  
Swelling of limbs: Yes No  
Thyroid problems: Yes No  
Tonsillitis: Yes No  
Tuberculosis: Yes No  
Tumor or growths: Yes No  
Ulcer: Yes No  
Venereal disease: Yes No  
Yellow jaundice: Yes No  
Other Conditions Not Listed Here:



2815 Grand Prairie Pkwy, Suite 3  
Waukee, IA 50263  
Ph: 515-500-1946  
Fax: 515-500-1947

## Female

Are you pregnant? Yes No

Are you nursing? Yes No

Are you taking birth control pills? Yes No

## Pharmacy

Pharmacy Name:

Pharmacy address:

Pharmacy zip code:

Pharmacy phone number:

**I have read my medical history and confirmed that it adequately reflects past and present conditions.**

**X** \_\_\_\_\_ **Date:** \_\_\_\_\_