Welcome

At Copper Canyon Dental your comfort, health and beautiful smile is our top priority.
We include a limited warranty on treatments you receive in our office.

Tell Us About Yourself

Date ___/___/___

Name: ______________________________________
Last first prefer name

Birth Date ______________ SS # ______________

Email address ______________________________

Employer ___________________________________

Phone ______________________________________
Home cell

Address ____________________________________

____
City State zip code

Emergency Contact __________________________
Name phone

Married ☐ Single ☐ Widowed ☐ Child ☐

Insurance

Subscriber Name: ___________________________

SS # __________________ DOB ______________

Insurance Co. ______________________________

ID # __________________ Group # ___________

Relationship to patient ____________________

Secondary Insurance Carrier

Subscriber Name: ___________________________

SS # __________________ DOB ______________

Insurance Co. ______________________________

ID # __________________ Group # ___________

Relationship to patient ____________________

Medical History

Medical Dr. ________________________________
Phone

List any medications you are now taking:

____

____

____

List any medications you are allergic to:

____

____

Have you ever had any of the following?

Y N Abnormal Bleeding
Y N Acid Reflux
Y N Any Hospital Stays
Y N Any Operations
Y N Artificial bones/joints
Y N Asthma
Y N Anemia
Y N Cancer
Y N Congenital heart defect
Y N Convulsions
Y N Diabetes
Y N Epilepsy
Y N Exposed to HIV
Y N Handicaps
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N Hives
Y N HIV/AIDS
Y N Kidney problems
Y N Liver problems
Y N Measles
Y N Mononucleosis
Y N Sickle Cell
Y N Tuberculosis

Severe gag reflex Y N

Tobacco Use? _______________________________

Alcohol Use? _______________________________

Any other medical conditions we should be aware of, or comments for the Dr.?

____

How did you hear about us? _________________

Dental Background

Any unusual reactions to dental injections? Y N   Severe Dental Anxiety? Y N

Is there anything you would like to change about your smile? ______________________________

When was your last dental visit? ____

Why did you leave your last dentist? ____

What did you like MOST about them? ____

Please rank from most important to least important: (one being the most important)

___Avoiding Pain ___Aesthetics ___Cost ___Teeth Function for a Lifetime __Keeping Your Teeth as Long as Possible

Which, if any, whitening products have you used?

___ Crest White-strips   ___ Custom trays w/gel   ___ ZOOM

- Copper Canyon Dental is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC & the ADA.
- For my convenience, this office may release my information to my insurance company, and receive payment directly from them. I hereby authorize payment directly Copper Canyon Dental of the insurance benefits otherwise payable to me. Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
- If an appointment is broken without a 24 hr notice, Copper Canyon Dental reserves the right to charge a broken appointment fee of $150 per hour, which I will be responsible for paying.
- Treatment plans may change, and I will be responsible for work actually done. I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary and advisable . I authorize Copper Canyon Dental to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.
- I understand that I am responsible for all costs and dental treatment. I agree to pay a finance charge of 1.5% per month on any balance 60 days past due, unless acceptable arrangements have been made. In the event my account is sent to collections, I agree to pay all related fees and court costs.
- I certify to the above statements regarding my medical condition. The information provided here by me is correct to the best of my knowledge.

Signature ____ Date __________________

If Patient is Under 18

Responsible Party _______________________________________ Relationship to Patient __________