Willow Creek Dentistry
Michael A. Muff, D.D.S.
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Chico, CA 95973
Office: 530.891.6611• Fax: 530.891.6638

FOR OFFICE USE ONLY

Resp. Party #_____
PT. # _____
INS. # P_____ S_____

Date _____
Patient Name: Last_____First _____Preferred _____ MI___
Address _____City _____ State_____ ZIP _____
Home #: (____)_____ Cell #: (____)_____ Work #: (_____)_____
Social Security Number _____ Date of Birth _____ Age_____
❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Single ❑ Minor Driver's License No.: _____
Email Address _____
Best way to confirm appointments ❑ Call:(____) _____ ❑ Email ❑ Text Message
Who referred you to our office? _____

Name: Last: _____ First _____ MI _____
Relationship to Patient _____
Billing Address _____City _____State _____ZIP _____
Home Phone Number: (____)_____ Driver's License No.: _____
Employer _____Occupation:_____
Business Address_____City _____State _____ZIP _____
Business Phone Number: (____)_____ Ext._____

SPOUSE/PARENT:

Name Last _____ First _____ MI _____
Relationship to Patient _____
Employer _____Occupation:_____
Business Address_____City _____State _____ZIP _____
Business Phone Number: (____)_____ Ext._____

Is patient covered by Dental Insurance? ❑ Yes ❑ No

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Incentive Program

PRIMARY DENTAL INSURANCE COMPANY: Name: _____
Insurance Co. Address_____City _____State _____ ZIP_____
Insurance Co. Phone Number: (_____)_____
Group Number # _____Local or Union Number_____
Employer Name _____
Name of Insured_____Relationship to Patient _____
Insured Social Security Number_____Date of Birth _____
Does patient have Additional Dental Insurance? ❑ Yes ❑ No If yes, complete the following:

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Incentive Program

SECONDARY DENTAL INSURANCE COMPANY: Name: _____
Insurance Co. Address_____City _____State _____ZIP_____
Insurance Co. Phone Number: (_____)_____
Group Number # _____Local or Union Number_____
Employer Name _____
Name of Insured_____ Relationship to Patient_____
Insured Social Security Number_____Date of Birth_____

1. I hereby authorize Dr. Muff and/or his staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by Dr. Muff to make a thorough diagnosis of my dental needs.

2. Upon such diagnosis, I authorize Dr. Muff 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 as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or 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 understand that a ***1 ½ late charge (18% APR)*** may be added to my account.

5. I have read and understand the Office Policy.

Patient's Signature **X**_____ Date _____

Signature of Parent or Responsible Party _____

Relationship to Patient **X**_____

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Date: _____

Employer: _____ Computer Assigned Ins. Plan #_____

Group Number: _____ Program Type:_____

Incentive Program: _____

Deductible: _____ Lifetime:_____

Individual: _____

Family:_____

Maximum: _____

UCR: _____ Table _____ Calendar Year: _____

Lifetime Maximum: _____

Benefit Level:

CAT I = Preventive/Diagnostic _____ %

CAT II = Basic _____ %

CAT III = Crowns_____ %

CAT IV = Fixed Bridges/Partials _____ %

CAT				
_____	Prophy:	2/YR	1/6 MOS	2/12 COS MOS
_____	Exam:	1/YR	2/YR	1/6 MOS
_____	BW'S Child:	1/YR	2/YR	1/6 MOS
_____	Adult:	1/YR	2/YR	1/6 MOS
_____	FMX:	36 MOS	5 YRS	
_____	Perio Maint:	Deduct Applies ❑ YES ❑ NO		
_____		(Prophy Guidelines Applies)		
_____	RT. Planning:	Deduct Applies ❑ YES ❑ NO		

Restorative: Post Comp: Downgraded ❑ YES ❑ NO
Plan Considers Upper # ____ to #____ Anterior Lower # ____ to # ____
Replacement Period: ❑ YES ❑ NO _____MONTHS

Crowns: Waiting Period: ❑ YES _____MONTHS ❑ NO
Replacement Allowed: 5 YRS 7 YRS

Bridge & Partials Waiting Period: ❑ YES _____MONTHS ❑ NO
Prior X/O's Covered: ❑ YES ❑ NO
Replacement Allowed: 5 YRS 7 YRS

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)

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 _____

WILLOW CREEK DENTISTRY

Appointment Cancellation Policy

We pride ourselves in providing quality dental care to our patients in a timely and personal manner. Missed appointments and same-day cancellations impede our ability to accomplish this goal.

We therefore require a minimum of 24 hours notice to cancel or reschedule your appointment. This policy helps to keep our practice running on time and gives us an opportunity to accommodate patients who need to be seen on short notice.

If you cancel or reschedule your appointment without 24 hours notice, or fail to show up as scheduled, you will be subject to a broken appointment fee. We will do our best to fill your appointment slot, but if we are unable to do so on such short notice, there will be a $42 charge.

We greatly appreciate your patronage and your understanding regarding this policy.

I, _____, have read the Appointment Cancellation

Policy and agree to its terms.

Signature_____ Date_____

Willow Creek Dentistry 2765 Esplanade Chico, Ca 95973 (530) 891-6611

Notice of Privacy Practices

All information that is obtained from you by this office is protected and kept confidential. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced.

Uses and Disclosure

- Your protected health information is accessed and used for healthcare related purposes only.
- Your protected health is never sold, rented, transferred, exchanged and/or used for non-healthcare related purposes including marketing activities without your written consent.
- Your protected health information is disclosed to third party entities without your written authorization for the purpose of treatment, to obtain payment for each treatment, and for healthcare operations.

Certain Circumstances

Your protected health information can be disclosed without your written authorization in certain limited circumstances:

- Medical emergencies
- In situations required by law
- Individuals involved in your care
- When requested by public health agency
- When requested by a law enforcement agency

For any purpose other than treatment, obtaining payment, healthcare operations, or certain circumstances, we will ask for your written authorization to disclosed protected health information, you can revoke that authorization in writing at any time.

Patient Rights

- You have the right to request in writing to inspect and/or receive a copy of your health information.
- You have the right to request an alternate means or location to receive communications regarding your health information.
- You have the right to request in writing to amend, correct, or delete any recorded health information within our possession.
- You have the right to request in writing an accounting of certain disclosures of your health information that were made in this office.

Conditions and limitations may apply; obtain additional information from front desk

Changes to this notice: We reserve the right to change privacy practice and the conditions of this notice at any time and without prior notice. In the event of changes, an updated notice will be posted and a copy will be made available to you.

Acknowledgement of Receipt of Privacy Practices Notice

This document acknowledges that you have received a copy of the Notice of Privacy Practices. This document is not a contract, authorization, release, or consent form. This document will remain in your records.

I _____ (Patient),
Acknowledge that I have received a copy of the Notice of Privacy Practices.

_____

Patient's Signature Date

If the patient is a minor, a parent or legal guardian must sign.

_____

Parent or Legal Guardian Date Relationship to Patient

If the patient is not a minor, but under the care of a relative, friend, or caregiver, sign here.

_____

Signature Date Relationship to Patient