AZ FAMILY DENTISTRY

Date _____

PATIENT INFORMATION (CONFIDENTIAL)

Please Circle

Name _____ **Male** **Female** Soc. Sec # _____

Address _____ City _____ State _____ Zip _____

Birth date _____ Home # _____ Work # _____ Cell # _____

Other #'s _____ E-mail _____

Circle Appropriate: Minor Single Married Divorced Widowed Separated

Patient's or Parents Employer _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____

If patient is a student, name of school/college _____ City _____ State _____

How did you hear about us? _____ Reason for leaving last dentist _____

Last dental X-rays _____ Last visit to dentist _____ Person to contact in case of emergency _____

Relationship _____ Phone _____

Has any other family member been in office? (Please circle) YES NO If yes, name _____

RESPONSIBLE PARTY

Relationship to Patient (circle one)

Name of Person responsible for this Account _____ **SELF** **SPOUSE** **CHILD** **OTHER**

Address _____ City _____ State _____ Zip _____

Driver's License # _____ Birth date _____

Home # _____ Work # _____

Is this person currently a patient in our office? Please Circle YES NO

INSURANCE INFORMATION

ID# _____ Relationship to Patient (circle one)

Name of Insured _____ **SELF** **SPOUSE** **CHILD** **OTHER**

Birth date _____ Soc. Sec. # _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Phone # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

***Do you have additional insurance?** (Please circle) YES NO *If yes, please complete the following:* Relationship to Patient (circle one)

Name of Insured _____ **SELF** **SPOUSE** **CHILD** **OTHER**

Birth date _____ Soc. Sec. # _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Phone # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

CONSENT

- I understand and hereby authorize the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
- I understand and authorize doctor to perform all recommend treatment mutually agrees upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ assistance as deemed fit to provide recommended treatment.
- I understand that if a minor is being treated for any dental service, that, an authorized adult must stay on the premises at all times during the reserved appointment time. I also understand that if an adult or minor is being treated for dental services, no other minors will be allowed to accompany them during the treatment.
- I understand that it is my responsibility to advice and notify AZ Family Dentistry of any changes in the information contained on this form.
- To the best of my knowledge the information provided on this page is true.

Patient _____ Date _____

Parent or Responsible Party _____ Relationship to Patient _____

AZ FAMILY DENTISTRY

Name:_____ Date of Birth: _____ Date:_____

Medical Information

Mark yes or no if you have or have had any of the following:

	YES	NO		YES	NO		YES	NO
AIDS/HIV Positive	☐	☐	Cortisone Medications	☐	☐	Liver Disease	☐	☐
Allergies or hives	☐	☐	Diabetes Type I Type I I	☐	☐	Mitral Valve Prolapse	☐	☐
Anemia	☐	☐	Drug Addiction	☐	☐	Nervousness / Anxiety	☐	☐
Arthritis/Rheumatoid Arthritis	☐	☐	Eating Disorder	☐	☐	Neurological Disorder	☐	☐
Artificial Heart Valve	☐	☐	Epilepsy or Seizures	☐	☐	Organ Transplant	☐	☐
Artificial joints (hips, etc)	☐	☐	Emphysema / Bronchitis	☐	☐	Osteoporosis	☐	☐
Asthma	☐	☐	Eye Disease / Glaucoma	☐	☐	Redux / Fen-Phen	☐	☐
Autoimmune Disease	☐	☐	Fainting / Dizzy Spells	☐	☐	Rheumatic / Scarlet Fever	☐	☐
Bleeding Disorder	☐	☐	Gastrointestinal Disease	☐	☐	Severe Gain / Loss of weight	☐	☐
Blood Transfusion	☐	☐	Hay Fever	☐	☐	Sexually Transmitted Disease	☐	☐
Breathlessness	☐	☐	Heart Pacemaker / Surgery	☐	☐	Sinus Problems	☐	☐
Cancer	☐	☐	Heart Disease or Attack	☐	☐	Stroke	☐	☐
Chemotherapy/ Radiation	☐	☐	Heart Murmur	☐	☐	Sub-acute bacterial Endocarditis	☐	☐
Chest Pain	☐	☐	Herpes	☐	☐	Thyroid Problems	☐	☐
Chronic Cough	☐	☐	Hepatitis (A, B, C, D, E)	☐	☐	Tuberculosis	☐	☐
Chronic Headaches	☐	☐	High / Low Blood Pressure	☐	☐	Ulcers	☐	☐
Colitis	☐	☐	Kidney Problems	☐	☐			
Congenital Heart Disease	☐	☐	Latex Allergy	☐	☐			

Are you taking any Bishosphonates? Such as Actonel / Fosamax / Aredia / Zometa YES OR NO

Do you have or have you had any diseases, conditions, or problems not listed? If so please list._____

Do you smoke or chew tobacco? If yes, how much per day? _____

FOR WOMEN ONLY YES NO YES NO YES NO

Is there any possibility of pregnancy? ☐ ☐ What month? _____ Are you nursing? ☐ ☐ Are you taking birth control? ☐ ☐

	YES	NO
Are you having pain or discomfort at this time?	☐	☐
Have you been a patient in the hospital during the past two years?	☐	☐
Have you been under the care of a medical doctor or been hospitalized?	☐	☐
Physician's Name _____ Phone _____		
Address _____		
Have you had any previous surgeries?	☐	☐
Procedures & dates _____		
Have you had any history of drug abuse or addiction?	☐	☐
Are you now taking any medications or drugs?	☐	☐
If yes, please list: _____		
Are you sensitive or allergic to any medications or anesthetics?	☐	☐
If yes, please list: _____		
Have you had any problems with anesthesia?	☐	☐

Dental History

	YES	NO		YES	NO
Do your gums bleed when you brush or floss?	☐	☐	Do you clench or grind your teeth?	☐	☐
Are your teeth sensitive to hot or cold liquids/food?	☐	☐	Do you bite your lips or cheeks frequently?	☐	☐
Do you feel pain in any of your teeth?	☐	☐	Have you had any orthodontic work?	☐	☐
Do you have any sores/lumps in or near your mouth?	☐	☐	Have you ever had any difficult extractions in the past?	☐	☐
Have you had any head, neck, or jaw injuries?	☐	☐	Have you ever had prolonged bleeding following extractions?	☐	☐
Do you have frequent headaches?	☐	☐	Have you ever experienced the following: (please circle)		
Do you floss your teeth?	☐	☐	Clicking, Pain (ear, side of face, joint), Difficulty in opening/closing, Difficulty chewing		

Patient Signature: _____

Doctor's Signature: _____

AZ FAMILY DENTISTRY

5690 W. Chandler Blvd., Ste 1
Chandler, AZ 85226
(480)753-1111

NOTICE OF PRIVACY PRACTICES

Patient Acknowledgement of Receipt

(Patient may refuse to sign this agreement)

This Healthcare Practice recognizes that patients have the Right of Privacy concerning their personal health information. We make every effort to protect and preserve patient records in a manner that secures this information.

By signing this Acknowledgement:

You are only confirming that you received a copy of our PRIVACY PRACTICES

You do not give up any of your Rights and you may choose at some point in the future to provide more specific instructions for us to follow regarding your personal health information.

I have received a copy of this office's Notice of Privacy Practices:

Print your name here: _____

Sign your name here: _____

Print today's date here: _____

AZ FAMILY DENTISTRY

5690 W. Chandler Blvd., Suite 1
Chandler, AZ 85226
Ph: (480) 753-1111 Fax: (480) 765-1112

Financial Agreement

Payment is due at the time of your dental services unless other arrangements have been made with the Practice Manager.

As a courtesy we will bill most dental insurance plans. *However, as a patient, it is your responsibility to understand your benefit pan (i.e., maximums, benefit exclusion & limitations plan).* Please be advised we will estimate your dental insurance benefits when possible. You will be responsible for any amount not covered by your insurance.
_____ Initials

We reserve time for each patient. There will be a fee of $25.00 added to your account if you fail to cancel your appointment within 24 hours. _____ Initials

There will be a fee of $30.00 for each NSF (non sufficient funds) check that is returned by your bank.
_____ Initials

All patients portions are due upon services rendered. In the case where we are billing your insurance we may send you a statement for the remaining patient portion which is due upon receipt. _____ Initials

For all patient balances that become older than 90 days there will be a late charge of 18% added to the balance of the account. _____ Initials

Methods of payments available

☐ Cash ☐ Check ☐ Auto Payment ☐ Credit Card

Patient/Guardian Signature: _____

Date: _____