Noll Family Dentistry

8801 W. Union Hills Dr., Bldg B.
Peoria, AZ. 85382
(623) 974-0321

Whom may we thank for referring you to our office? ____

PATIENT INFORMATION

Date: ___________ Patient's Name: ____ DOB: _____/____/_______

First Middle initial Last

If patient is a minor give parents/guardian name: ____

Address: ____

Street Apt# City State Zip

Social Security #: ______/_______/__________Email: ____

Home Phone: (____) ___________ Cell phone: (____) _____________ Work phone: (___) ______________

Emergency contact name:_________________________________ **Phone:** ____________________________

Relationship to Patient: ____________________________________

RESPONSIBLE PARTY or INSURANCE SUBSCRIBER INFORMATION

Name: ____ Birthdate: _________

First Last Middle

Address: ____

Street apt # City State Zip

Home phone: _____________________cell phone: ________________work phone: ____________________

Relationship to patient: ________________________________

Employer: _____________________________________Social Security number: _______/_____/________

Dental Insurance Company: __________________________ID#________________ Group# ____________

Dental insurance address: ____

Phone number of Insurance: (____) ______________________

Do you have secondary dental insurance? (Dual Coverage)

Name: ____Birthdate: ______/________/_________

Employer: ____

Dental Insurance company: ________________________________Group#__________ID#_______________

Insurance Phone number: ___________________________

PAYMENT RESPONSIBILITY

Patients without dental insurance…I understand that all responsibility for dental services provided in this office for myself or dependents is mine, due and payable as services are rendered.
Patients with dental insurance …. I understand that all services and fees may not be fully covered by the insurance. I understand that I am **responsible** for payment of **ALL dental services** provided for myself or my dependents. My estimated co pay is due and payable at the time services are rendered. Any unpaid balance after insurance has paid their portion is due upon receipt of statement. If it become necessary to enlist a collection agency, responsible party agrees to pay all costs of collection.
I authorize the use of my name on dental claims for services provided to me and my dependents. I authorize payment of claims to this office. I also understand that it is my responsibility to inform the office of any changes in information.

Patient or Responsible Party: ____Date: ________________

Dental History

Do you have any specific dental problem? Yes ________ No________

Describe: ____

Do you have routine dental cleaning and exams? Yes_______ No________

Last visit: ____

Do your gums ever bleed? Yes _____ No______
If so, discuss ____
Do you ever have clicking, popping or discomfort in the jaw joint?
____

Do you smoke or chew? Yes_______ No________

Any sores or growths in your mouth? Yes_______ No________

Patient Name: ________________________________ DOB: __________________ Date: _________________

Medical History

Do you have a primary care physician? _____ Name: ___________________________ Phone:_____________________
Do you have a preferred pharmacy? ____ Phone: _________________
Have you been hospitalized or had a major operation in the past year? Yes________ No _________
If so please list: ____
Are you taking any medications? Please list or provide a copy: _____________________________________
____
Are your **allergic** to any medications or substances? _____ Please list: ______________________________
____
For **Women:** Pregnant? ____ Trying to get pregnant? _____ Nursing? _____ Taking oral contraceptives? ___

Do you have, or have you had, any of the following conditions?			
○ Asthma	○ Dizziness	○ Irregular Heart Beat	○ Yellow Jaundice
○ Anemia	○ Drug Addiction	○ Intestinal Disease	○ Artificial Joint
○ AIDS	○ Diabetes	○ Kidney Disease	__________year of
○ Angina Chest Pain	○ Dementia	○ Lung Disease	replacement and is:
○ Arthritis	○ Dental Anxiety	○ Low Blood Pressure	○ Pre-Med Needed
○ Allergies	○ Epilepsy/Seizures	○ Leukemia	(Antibiotic)
○ Alzheimer’s	○ Frequent Cough	○ Liver Disease	
○ ADHD/ADD	○ Gout	○ MVP	
○ Asperger Syndrome	○ Glaucoma	○ Osteoporosis	
○ Autism	○ Heart Valve	○ Psychiatric Care	
○ Blood Thinner	○ Heart Pacemaker	○ Pace Maker	
○ Blood Disease	○ Heart surgery	○ Renal Dialysis	
○ Blood Transfusion	○ High Blood Pressure	○ Radiation Treatment	
○ Bruise Easily	○ Heart Disease	○ Stroke	
○ Breathing Problems	○ Heart Murmur	○ Special Needs	
○ Bipolar	○ Heart Attack	○ Thyroid Disease	
○ Cancer	○ Hypoglycemia	○ Tuberculosis	
○ Chemotherapy	○ Hepatitis: A B C	○ Tumors	
○ Celiac Disease	○ HIV Positive	○ Tuberculosis	
○ Crohn’s Disease	○ Herpes	○ Ulcers	
○ Cold Sores	○ Hives/Rash	○ Vertigo	

Have you ever had a serious illness not checked above? Discuss Below:
____

X____Date__________________________
Patient Signature (Parent or Guardian)

Reviewed by Doctor_______________________________Date__________________________

Authorization to Treat Patient

1. **After being informed** I hereby authorize and direct the dentist(s) of Noll Family Dentistry and or/dental auxiliaries to perform the following dental treatment, including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.
   A. Preventive hygiene treatment (teeth cleaning) and the application of topical fluoride.
   B. Application of "sealants" to the grooves of the teeth.
   C. Treatment of diseased or injured teeth with restorations of composite (white filling), amalgam (silver filling) or crown.
   D. Replacement of missing teeth with fixed permanent dental bridges, partial dentures, or full dentures.
   E. Removal (extraction) of one or more teeth.
   F. Treatment of diseased or injured oral tissue (hard or soft) *Periodontal disease
   G. Treatment of crooked teeth and/or development or growth abnormalities.
2. I understand that there are risks involved in any dental treatment and hereby acknowledge that these risks will be explained to me and will have the opportunity to ask questions regarding the treatment so that I fully understand.
3. I agree to the use of local anesthesia, nitrous oxide analgesia (laughing gas) when applicable. I understand that the use of nitrous oxide gas may cause dizziness and nausea. I understand and have been informed of any risks or complications.
4. **After being informed**, I therefore authorize and request performance of any additional dental procedures that are deemed necessary or desirable to oral health and well-being in the professional judgement of the treating dentist.
5. I recognize that during the course of treatment unforeseen circumstances may arise and therefore necessitate additional or different procedures from those discussed. After consultation, I authorize and request the performance of any additional procedures that are deemed necessary by the treating dentist for better oral health.
6. I will be advised that the success of the dental treatment to be provided will require that the patient and/or guardian/parents follow all post care instructions. I agree that the success of the treatment requires that all instructions be followed and regular dental visits be maintained.
7. I hereby state that I have read and understand this consent and that any questions about the dental procedures will be answered to the best professional knowledge of the treating dentist and/or dental auxiliaries.
8. I **have the right to be provided answers to questions that may arise during the course and after dental treatment.**
9. **I further understand that this consent will remain in effect until such time I choose to terminate it.**

Patient's Name: (please print) ______________________________

Guardian or Parent: ______________________________________

(If applicable)

Signature: ____

Patient, Parent or Guardian

NOTICE OF PRIVACY PRACTICES (HIPAA) FOR THE OFFICE OF:

MATTHEW G. NOLL, DDS TRACY L. MACKEY, DDS

I have been informed of this office's privacy practices. Information will not be shared or used unless expressed written consent has been given.

Please list the names that are authorized to received information regarding your care:

1. ____
2. ____
3. ____

PATIENT NAME: ____

Please Print

SIGNATURE: ____

Patient, Guardian or Representative of patient

PERMISSION TO EMAIL OR TEXT FOR COMMUNICATION PURPOSES. Y or N

SIGNATURE: ____

DATE: ________________________

FOR OFFICE USE ONLY

- We attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:
- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other: ____

<u>CANCELLATION POLICY (AS OF 06/28/2023)</u>

WE HAVE A 24 HOUR CANCELLATION POLICY. IF YOU ARE UNABLE TO KEEP YOUR SCHEDULED APPOINTMENT, KINDLY GIVE A 24 HOURS NOTICE. IF NOT, YOU WILL BE RESPONSIBLE FOR A $25 CANCELLATION FEE.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE.

PATIENT NAME: ____________________________________

PATIENT SIGNATURE: _______________________________

DATE: ____