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?

o Asthma	o COPD	o Hemophilia	o Stroke
o Anemia	o Celiac Disease	o Hypoglycemia	o Special Needs
o AIDS	o Crohn's Disease	o Hyperglycemia	o Thyroid Disease
o Angina/Chest Pain	o Cold Sores	o Hepatitis: A B C	o Tuberculosis
o Arthritis	o Deaf	o HIV	o Tobacco User
o Allergies	o Depression	o Herpes	o Trigeminal Neuralgia
o Alzheimer's	o Down Syndrome	o High Blood Pressure	o Tremor
o ADHD/ADD	o Drug Addiction	o High Cholesterol	o Ulcers
o Acid Reflux	o Diabetes	o Irregular Heart Beat	o Vertigo
o Autism	o Dementia	o Intestinal Disease	o Jaundice
o Blind	o Dental Anxiety	o Kidney Disease	o Artificial Joint _____year of replacement and is:
o Blood Thinner	o Epilepsy/Seizures	o Lung Disease	o Pre-Med Needed (Antibiotic)
o Blood Disease	o Frequent Cough	o Low Blood Pressure	
o Blood Transfusion	o Fibromyalgia	o Leukemia	
o Bruise Easily	o Gout	o Liver Disease	
o Breathing Problems	o Glaucoma	o MVP	
o Bipolar	o Heart Valve	o Multiple Sclerosis	
o Cancer	o Heart Pacemaker	o Osteoporosis	
Type: _____	o Heart Surgery	o Parkinson's Disease	
Remission: Yes__ No__	o Heart Disease	o Renal Dialysis	
Date: _____	o Heart Murmur	o Radiation Treatment	
o Chemotherapy	o Heart Attack	o Sjogren's Syndrome	

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: _____

CANCELLATION POLICY (AS OF 06/28/2023)

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: _____