AZ ORAL HEALTH CENTER

5900 N. Granite Reef Rd. Suite #100 Scottsdale, AZ 85250 T: 480.977.1440

PATIENT INFORMATION

❑ Female ❑ Male

Name _____
LAST FIRST MIDDLE INITIAL PREFERRED NAME

Address _____
STREET

_____
CITY STATE ZIP

Employer _____ Occupation _____

Birth date _____ Height _____ Weight _____

Phone: Home (_____) _____

Work (_____) _____ Driver's License # _____

Cell (_____) _____ E-mail Address _____

I give AZ Oral Health Center permission to leave detailed information concerning my dental health on my voicemail YES❑ NO ❑

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Domestic Partner

How did you hear about our office? _____

Do you prefer to be contacted via email, phone, text? _____ Are we able to contact you via text message YES❑ NO ❑

DENTAL INSURANCE

Primary DENTAL Carrier

Subscriber Name _____ Relationship to Patient _____ Subscriber DOB _____

Subscriber SSN/ID _____ Subscriber Employer _____

Insurance Company Name _____

Insurance Company Address _____

Insurance Company Phone _____ Group Number _____

Secondary DENTAL Carrier

Subscriber Name _____ Relationship to Patient _____ Subscriber DOB _____

Subscriber SSN/ID _____ Subscriber Employer _____

Insurance Company Name _____

Insurance Company Address _____

Insurance Company Phone _____ Group Number _____

Insurance Authorization Statement (Sign & Date)

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to AZ Oral Health Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party (Print name): _____ Relationship: _____

Responsible Party Signature: _____ Date: _____

MEDICAL HISTORY

What is the **name** and **phone number** to your Preferred Pharmacy _____

Do you have a personal physician ❑ Yes ❑ No Physician's Name_____

Physician's Phone_____ Date of last visit _____ Your current physical health is ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician ❑ Yes ❑ No Please explain _____

_____

Do you use tobacco ❑ Yes ❑ No If yes, what form of tobacco _____ How Often _____

Do you use Marijuana ❑ Yes ❑ No If yes, what form of marijuana _____ How Often _____

Any prior or current drug or alcohol abuse problems ❑ Yes ❑ No Please explain _____

Have you had metal rods, pins or implants placed ❑ Yes ❑ No Did you premedicate with antibiotics prior to dental work ❑ Yes ❑ No

Are you taking any medications and/or supplements at this time ❑ Yes ❑ No Please list each one _____

_____

Are you currently taking, have previously taken, or scheduled to take any medication (IV and/or prescription) to treat **Osteoporosis/Paget's Disease, Multiple Myeloma or Metastatic Cancer** *Commonly-Prescribed drugs include Fosamax®, Actonel®, Boniva®, Reclast®, Prolia®, Zometa®, Aredia®, Xgeva® ❑ Yes ❑ No Please explain and list dates _____

_____

Have you ever had any surgical procedures ❑ Yes ❑ No Please list each one with dates _____

Yes	No	Conditions
❑	❑	Abnormal Bleeding
❑	❑	ADHD or Developmental Disability
❑	❑	Alcohol Abuse
❑	❑	Allergies
❑	❑	Alzheimer's Disease or Dementia
❑	❑	Anemia
❑	❑	Angina Pectoris
❑	❑	Arthritis
❑	❑	Artificial Heart Valve
❑	❑	Asthma
❑	❑	Autism
❑	❑	Blood Transfusion
❑	❑	Cancer
❑	❑	Chemotherapy
❑	❑	Colitis
❑	❑	Congenital Heart Defect
❑	❑	Diabetes
❑	❑	Difficulty Breathing
❑	❑	Drug Abuse
❑	❑	Eating Disorders
❑	❑	Emphysema
❑	❑	Epilepsy
❑	❑	Facial Surgery
❑	❑	Fainting Spells/Syncope
❑	❑	Fever Blisters

Yes	No	Conditions
❑	❑	Frequent Headaches
❑	❑	GERD
❑	❑	Glaucoma
❑	❑	Heart Attack
❑	❑	Heart Murmur
❑	❑	Heart Surgery
❑	❑	Hemophilia
❑	❑	Hepatitis A B or C
❑	❑	High Blood Pressure
❑	❑	High Cholesterol
❑	❑	HIV+ AIDS
❑	❑	Jaw Pain
❑	❑	Joint Replacement
❑	❑	Kidney Problems
❑	❑	Liver Disease
❑	❑	Low Blood Pressure
❑	❑	Migraines
❑	❑	Mitral Valve Prolapse
❑	❑	Osteoarthritis/ Bone Disease
❑	❑	Pace Maker
❑	❑	Parkinson's Disease
❑	❑	Psychiatric Problems
❑	❑	Radiation Therapy
❑	❑	Rheumatic Fever
❑	❑	Seizures

Yes	No	Conditions
❑	❑	Sexually Transmitted Disease
❑	❑	Shingles
❑	❑	Sickle Cell Disease
❑	❑	Sinus Problems
❑	❑	Stroke
❑	❑	Thrush
❑	❑	Thyroid Problems
❑	❑	TMJ Issues
❑	❑	Tuberculosis
❑	❑	Ulcers

Yes	No	**Allergies**
❑	❑	Aspirin
❑	❑	Codeine
❑	❑	Dental Anesthetics
❑	❑	Erythromycin
❑	❑	Ibuprofen
❑	❑	Jewelry / Metals
❑	❑	Latex
❑	❑	Nickel
❑	❑	Penicillin/Amoxicillin
❑	❑	Sulfa Drugs
❑	❑	Tetracycline

Yes	No	**If Female, Please Answer**
❑	❑	Are you taking Birth Control Pills
❑	❑	Are you pregnant If so, # of Weeks____
❑	❑	Are you nursing

Nearest relative not living with you: Name _____ Relationship: _____

Address: _____ Phone: _____

Emergency contact: _____ Relationship: _____ Phone: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____

Office Use Only: **Health History Reviewed by** _____ **Date** _____

DENTAL HISTORY

How may we help you today? _____

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do you wear a mouthguard / bite-guard / sports guard / sleep appliance? Retainers❑ Yes ❑ No **If yes, circle which one**

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Are you currently in pain? ❑ Yes ❑ No

Have you ever had gum treatment? ❑ Yes ❑ No

Do you now or have you had any pain/discomfort in your joint? (TMJ) ❑ Yes ❑ No

Are you under stress? (new job, moving, relationships) ❑ Yes ❑ No

Do you like your smile? ❑ Yes ❑ No

Is there anything you would like to change about your smile? ❑ Yes ❑ No

Are you happy with the color of your teeth? ❑ Yes ❑ No

Have you ever whitened your teeth? ❑ Yes ❑ No

Do your gums bleed? ❑ Yes ❑ No

How many times a do you: floss/week _____ brush/day? _____

Are your teeth sensitive to heat, cold or anything else? ❑ Yes ❑ No

Have you ever had a serious/difficult problem with any previous dental work? ❑ Yes ❑ No

Have you ever had any unfavorable dental experiences? ❑ Yes ❑ No

When was your last dental cleaning? _____

When was your last dental visit? _____

Why did you leave your previous dentist? _____

What is your favorite genre of music? _____

How can we accommodate you better during your dental visit? _____

_____

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient Signature: _____

(Guardian Signature if patient is a minor)

Here at AZ Oral Health Center, we offer a wide variety of services to enhance and keep your smile beautiful.
Please circle any services below you would like our friendly staff to discuss with you during your visit.

Tooth Whitening	Veneers	Invisalign
Smile Makeover	Bonding	Sealants
Crown and Bridge	Dental Implants	Partials/Dentures
Night/Sport Guards	Electric Toothbrush	WaterPik

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I, _____, have received a copy of this office's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy from time to time and that I may contact this organization at any time to obtain a copy of the Notice of Privacy Practices.

Patient Name_____

Relationship to Patient_____ (if Patient is a minor)

Signature_____ Date_____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy, but was unable to do so as documented below:

Date Initials Reason_____

AUTHORIZATION TO SPEAK TO FAMILY MEMBER

I, _____, give permission to AZ Oral Health Center to

disclose the following protected health information to _____.

The relationship to the patient is _____.

Information to be disclosed (check all that apply)

- ☐ Financial / Payment / Insurance Records
- ☐ Dental Treatment Records, including X-rays
- ☐ Dental Treatment Plans

Signature of Patient_____ Date_____

Expiration date of authorization _____

FINANCIAL POLICIES

Thank you, for choosing our office for your dental needs. We are committed to your treatment being successful and are always available to answer your questions or assist you in any way we can. The follow is a statement of our financial policy, which we require you to read and sign prior to any treatment.

- **All patients** must complete all forms prior to being seen by the doctor
- All treatment estimates are valid for 90 days
- **Full payment** is due at the time of service. We accept Visa, Master Card, Discover, CareCredit and debit cards
- A $35 charge is incurred for returned checks
- Any balance left unpaid after 90 days will be turned over to small claims or collections and the patient will be dismissed from the practice
- Patient is responsible for any and all attorney fees, collection fees and finance charges should the account be turned to a collection agency

Regarding Insurance We accept assignment of insurance benefits. The balance is YOUR RESPONSIBILITY whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. Please be aware that the estimates that are given are just that. We do not guarantee insurance coverage or benefits. Please be aware that some or all of the services provided may not be a covered service under your insurance plan. **It is your responsibility to find out what is and is not covered.** You will be responsible for any balance not paid by your insurance company.

Medical Insurance Billing AZ Oral Health Center will bill your medical insurance on your behalf only if the Doctor decides it is a medically appropriate case for medical billing. Once that is done, our team will monitor the process to make sure the claims are paid at the highest reimbursement rate. After claims are paid, the balance on your account will be adjusted and the reimbursement will be distributed to the outstanding balance on your account. The amount you pay for the services provided are at a discounted rate, hence the amount paid by your medical insurance will be assigned to your outstanding balance.

Minors The adult accompanying a minor to his/her appointment is responsible for payment at the time of service. Minors will not be treated if unaccompanied.

Missed Appointments Unless cancelled at least **48 hours in advance**, our policy is to charge for missed appointments at the rate of $35 per half hour. This will help us cover a portion of our costs to make up for the time **especially reserved for you**. Please help us serve you better by keeping your scheduled appointments! Excessive missed or cancelled appointments will result in dismissal from the practice.

Thank you for understanding our Office Policy. Please feel free to let us know if you have any questions or concerns.

I have read, understand, and agree to the above financial policy.

Patient or responsible party (Printed name) _____

Patient or responsible party's Signature _____ Date_____

CONSENT TO DENTAL PHOTOGRAPHY

I, _____ (patient), authorize AZ Oral Health Center, to take photographs and/or videos of my face, jaws and teeth, before, during and after treatment. I consent to allow the photographs to be used for the following:

Initial only those you consent to or opt out below

- ☐ Dental Records
- ☐ Dental Research
- ☐ Dental Education including lectures, seminars, professional publication
- ☐ Marketing material including social media, printed materials and patient education

☐ Check here if you don't want your **full face (TEETH ONLY)** used for any of the above purposes

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential.
I do not expect compensation, financial or otherwise, for the use of these photographs.

☐ Check here if you want to OPT OUT of all

Patient Signature _____

Date _____