PATIENT NAME _____ **DATE** _____

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

Dental History

Please Circle

Do you have a specific dental problem? Describe _____ Yes No
Do you have dental examinations on a routine basis? Last visit _____ Yes No
Do you think you have active decay or gum disease? _____ Yes No
Do you brush and floss on a routine basis? Discuss _____ Yes No
Do your gums ever bleed? Discuss _____ Yes No
Do you like your smile? Why? _____ Yes No
Does food catch between your teeth? Any loose teeth? _____ Yes No
Do you want to keep your remaining teeth? _____ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No
Have your past experiences in a dental office always been positive? _____ Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ Yes No
Name of previous dentist (optional): _____
Date of last full mouth x-rays (16 small films or panoramic): _____

Medical History

Are you under a physician's care now? Why? _____ Who? _____ Phone _____ Yes No
Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
Have you ever had a serious injury to your head or neck? Discuss _____ Yes No
Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? What? _____ Yes No
Are you on a special diet? Discuss _____ Yes No
Are you allergic to any medications or substances? Please check box below _____ Yes No

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Milk ☐ Other _____

Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives Discuss _____ Yes No

Do you now have or have you ever had any of the following? Do you take any of these medicines? Please check appropriate boxes.

*If yes to any of the starred conditions, please call prior to your appointment... premedication or changes in medication may be required.

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease/Surgery*	☐	☐	Excessive Bleeding	☐	☐	Chemotherapy	☐	☐	Night Sweats	☐	☐	Cold Sores	☐	☐
Heart Murmur or Defect *	☐	☐	Sickle Cell Disease	☐	☐	Osteoporosis	☐	☐	Yellow Jaundice	☐	☐	Fever Blisters	☐	☐
Irregular Heart Beat	☐	☐	Hemophilia	☐	☐	Bisphosphonates	☐	☐	Kidney Problems	☐	☐	Herpes	☐	☐
Angina/Chest Pain	☐	☐	Methemoglobinemia	☐	☐	Osteonecrosis of Jaw	☐	☐	Renal Dialysis	☐	☐	Stroke	☐	☐
Heart Attack/Failure	☐	☐	Leukemia	☐	☐	Aredia I.V. Reclast I.V.	☐	☐	Thyroid Disease	☐	☐	Convulsions	☐	☐
Congenital Heart Disorder*	☐	☐	Recent Blood Transfusion	☐	☐	Zometa I.V.	☐	☐	Parathyroid Disease	☐	☐	Epilepsy or Seizures	☐	☐
Mitral Valve Prolapse *	☐	☐	Swelling of Limbs	☐	☐	Fosamax, Actonel, Boniva	☐	☐	Arthritis/Gout	☐	☐	Fainting or Dizziness	☐	☐
Scarlet Fever	☐	☐	Lung Disease	☐	☐	Stomach/Intestinal Disease	☐	☐	Rheumatism	☐	☐	Glaucoma	☐	☐
Rheumatic Fever *	☐	☐	Breathing Problem	☐	☐	Ulcers	☐	☐	Pain in Jaw Joints	☐	☐	Tumors or Growths	☐	☐
Artificial Heart Valve *	☐	☐	Shortness of Breath	☐	☐	Recent Weight Loss	☐	☐	Cortisone Medicine	☐	☐	Nervousness	☐	☐
Heart Pace Maker*	☐	☐	Frequent Cough	☐	☐	Frequent Diarrhea	☐	☐	Artificial Joint *	☐	☐	Psychiatric Care	☐	☐
Pulmonary Shunt*	☐	☐	Hay Fever	☐	☐	Diabetes	☐	☐	Sexually Transmitted Disease	☐	☐	Alzheimer's Disease	☐	☐
High Blood Pressure	☐	☐	Sinus Trouble	☐	☐	Excessive Thirst	☐	☐	AIDS	☐	☐	Allergies (Medicines)	☐	☐
Low Blood Pressure	☐	☐	Asthma	☐	☐	Hypoglycemia	☐	☐	HIV Positive	☐	☐	Allergies (Pollen / Dust)	☐	☐
Bacterial Endocarditis*	☐	☐	Bloody Sputum	☐	☐	Liver Disease	☐	☐	Genital Herpes	☐	☐	Hives or Rash	☐	☐
Unexplained Fever	☐	☐	Emphysema	☐	☐	Hepatitis A (Infectious)	☐	☐	Drug Addiction/Alcoholism	☐	☐	Need Premedication?	☐	☐
Bruise Easily/Blood Disease	☐	☐	Tuberculosis	☐	☐	Hepatitis B or C	☐	☐	Tattoos/Body Piercing	☐	☐	Ever taken fen-phen?*	☐	☐
Anemia	☐	☐	Cancer	☐	☐	Protease Inhibitor	☐	☐	Sleep Apnea	☐	☐	Cochlear implants?	☐	☐
Coronary Stent*	☐	☐	X-Ray Treatments (Radiation)	☐	☐									

Have you ever had any other serious illness not checked above? Discuss _____ Yes No
Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor _____ Date _____ BP _____ Pulse _____
History Review and Significant Findings _____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	PULSE	REVIEWED BY
		None ☐				Dr.
		None ☐				Dr.
		None ☐				Dr.
		None ☐				Dr.
		None ☐				Dr.
		None ☐				Dr.

DENTAL AND MEDICAL HISTORIES - UPDATES

PATIENT REGISTRATION FORM

PATIENT NAME: _____

ADDRESS: _____

PHONE (HOME):( )_____ (WORK):( )_____ (CELL):( )_____

EMAIL: _____

DATE OF BIRTH :_____ AGE:_____ PATIENT SOCIAL SECURITY #:_____

SEX: Male Female MARITAL STATUS: Single Married Other _____

SPOUSE OR NEAREST RELATIVE NAME:_____ PHONE:_____

ADDRESS:_____ CITY, STATE ZIP:_____

REFERRAL INFORMATION: WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

Another patient, friend ___ Another patient, relative ___ Dental Office ___ Yellow Pages ___ Dental Insurance ___ Other ___

NAME OF PERSON, OFFICE, INSURANCE OR OTHER:_____

RESPONSIBLE PARTY INFORMATION:

RESPONSIBLE PARTY NAME:_____ RELATIONSHIP TO PATIENT:_____

ADDRESS:_____ CITY, STATE ZIP: _____

PHONE (HOME): ( )_____ (WORK): ( )_____ (CELL): ( )_____

DATE OF BIRTH :_____ SOCIAL SECURITY #:_____ SEX: Male Female

EMPLOYMENT INFORMATION: The following is for: Patient ___ Responsible Party ___

EMPLOYER:_____ OCCUPATION:_____

ADDRESS:_____ CITY, STATE ZIP: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE

INSURANCE CO NAME:_____

INS. CO. ADDRESS:_____

POLICY HOLDER NAME:_____

RELATIONSHIP TO PATIENT:_____

EMPLOYER:_____

ID #:_____ GROUP NO.:_____

DATE OF BIRTH:_____

SOCIAL SECURITY #: _____

SECONDARY INSURANCE

INSURANCE CO NAME:_____

INS. CO. ADDRESS:_____

POLICY HOLDER NAME:_____

RELATIONSHIP TO PATIENT:_____

EMPLOYER:_____

ID #:_____ GROUP NO.:_____

DATE OF BIRTH:_____

SOCIAL SECURITY #:_____

AUTHORIZATION TO PAY: I hereby authorize payment directly to the Dental office of Stanley Dental, 8877 W. Union Hills Dr. Suite 600, Peoria, AZ 85382 for the dental benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for the charges not covered by my insurance. I hereby authorize Stanley Dental to perform diagnostic and therapeutic treatment necessary for proper dental care and to release any information required in the course of my treatment to other health care providers or third-party payors.

PATIENT SIGNATURE:_____ DATE:_____

PARENT/GUARDIAN:_____ DATE:_____

PATIENT INFORMATION

NOTICE OF PRIVACY PRACTICES

Stanley Dental
Michael Stanley DMD
8877 W. Union Hills Dr. Ste 600
Peoria, AZ 85382

THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCOLSED AND HOW YOU CAN GET ACCESS TO THIS INOFORMATION.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payments of health care operations. (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information.

1. Uses and Disclosures of Protected Health Information

Your PHI may be used and disclosed by your physician our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a hoe health agency that provides care to you. For example, your information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your dental/health care services. For example, obtaining approval for a hospital stay require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use of disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign you name and indicated your physician. We may also call you by name in the reception room when you physician is ready to see you. We may use or disclose your PHI, as necessary to contact you to remind you of your appointments.

We may use or disclose your PHI in the following situations without your authorization. These situations include as Required by Law, Public Health issues as required by law; Communicable Diseases; Health Oversight.; Abuse or Neglect; Food and Drug Ad; ministration requirements; Legal Proceedings; Law Enforcement.

We will not use your health information for marketing communications without your written authorization.

We may disclose to miliary authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence and other national security activities.

Michael Stanley DMD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our 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 (Please Specify)

_____

_____

_____

Consent to Treat & Financial Policy

I voluntarily and knowingly request and consent to the services, treatments and/or procedures recommended by Michael Stanley DMD to all diagnostic methods deemed appropriate by the dentist which may include, but not be limited to, x-rays, study models, imagery, and other aids. I authorize the dentist to perform all such services, treatments and/or procedures and to utilize all such diagnostic methods. Further, I acknowledge and understand that the dentist may engage the assistance of others in performing such services, treatments and/or procedures and in utilizing such diagnostic methods.

I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the services, treatments, procedures and/or diagnostic methods that have been recommended. I also understand that the use of anesthesia carries with it significant risks that have been explained to me.

I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by the dentist and others. I acknowledge that any insurance coverage or benefits that I may have is based on a contract between my insurance company and me, my spouse and/or my employer. The dentist is not a party to this contract and the services, treatments, procedures and/or diagnostic methods are provided to me. Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatments, procedures and/or diagnostic methods provided to me. As a courtesy to me, the dental office will bill my insurance company and I acknowledge that I will remain liable for any and all amounts not paid by the insurance company for any reason (including but not limited to the insurance company declining coverage after initially approving it) or if the insurance company fails for any reason to reimburse the dentist within 45 days after being billed by the dentist. I acknowledge that it is my responsibility to provide the dentist with my current insurance or managed care information and any changes thereto.

All returned checks will be subject to a $35 returned check fee. Any account balances that remain unpaid for 70 days from the date of service may be referred to a collection company or attorney. In the event this occurs, I understand that I will be liable for collection costs of $25. Further, in the event any unpaid account balance is referred to an attorney for collection, I agree also to be responsible for all costs and reasonable attorney's fees incurred in connection therewith.

I consent to the dentist's use and disclosure of my health information to my insurance company and any agent thereof. I hereby assign to the dentist all of the insurance benefits due to me for the services, treatments, procedures and/or diagnostic methods provided to me and I authorize my insurance company to make payment directly to the dentist for the costs associated therewith.

I further consent to be contacted by the dentist, any agent of the dental office, or any collection agency (or agent thereof) or attorney to whom an unpaid account balance has been assigned or referred by mail at any address that I provide to the dental office and/or by facsimile, email or phone number (whether a cell phone or landline) that I provide to the dental office or any agent of the dental office.

Patient Signature: _____

Print Name: _____

Guardian/Responsible Party, if minor: _____

Print Name: _____

Date: _____

Stanley Dental

Cancellation Policy

We set aside dedicated time in our office for your dental appointment. If You find it necessary to cancel, please provide 24-hour advance notice. Without proper notice, you may be charged a $25.00 fee which is subject to change without notice.

Signature _____