North Scottsdale Dental

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Welcome to our Practice

Chart#: _____ FOR OFFICE USE ONLY

Patient Name: _____* (Last) _____* (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:*** ○ Male ○ Female **Family Status:*** ○ Married ○ Single ○ Child ○ Other

Birth Date:* _____ **SS#:** _____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____* (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____* (Address 1) _____ (Address 2)

_____* (City) _____* (State) _____* (Zip Code)

Referral Information

Whom may we thank for referring you to our practice?

_____

Emergency Contact Information

Emergency Contact's Name, Phone Number and Relationship *

_____

_____

Employment Information

The following is for: ○ the patient ○ the person responsible for payment ○ both ○ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

Responsible Party Information:

Are you the responsible party? If no, please complete this section. * ○ Yes ○ No

The following is for: ○ the patient's spouse ○ the person responsible for payment ○ both ○ neither-not applicable

Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other

Birth Date: _____ **SS#:** _____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

Primary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) ___ (MI)

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: _____

Insurance Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

Secondary Dental Insurance

Name of Insured: _____ (Last) _____ (First) ___ (MI)

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Primary Medical Insurance

Name of Insured: _____ _____ _____
Last First MI

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: _____

Secondary Medical Insurance

Name of Insured: _____ _____ _____
Last First MI

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: _____

Do you have a secondary dental insurance, if yes, please provide information to the reception staff. ○ Yes ○ No

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

HIPAA

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically grant permission of my protected health care information to include treatment, account information to the persons indicated below.(Please enter name and relationship)

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Authorization For Use Or Disclosure Of Patient's Photo's and/or Video Images

grant North Scottsdale Dental, including agents, assigns, or other third party on its behalf the nonexclusive rights to photograph me, make recordings of my voice, and make combined audio visual recordings of me and my voice. I consent to the use of such information by North Scottsdale Dental for educational materials, publications, and websites. All rights to such materials is granted to North Scottsdale Dental for use. I consent for the use of the above materials for print, electronic, or other digital format including any authorized website. I consent that my full name can be used in any such materials in print, electronic, or digital formats.

☐ **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Authorization For Use Or Disclosure Of Patient Photographic and/or Video Images.**

Medical History

Are you now under the care of a physician? * * ○ Yes ○ No

If yes, please explain:

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you had any serious illnesses, or have been hospitalized in the last 5 years? If yes please explain

☐ *Pre-Med
☐ Allergy-Gluten
☐ Allergy-Medication
☐ Anemia
☐ Artificial Jnt/valve
☐ Bipolar
☐ Blood Pressure-Low
☐ Chest Pains
☐ COVID + test
☐ Fainting/Dizziness
☐ Global Trans. Amensi
☐ Heart- Pacemaker
☐ Hospitalization
☐ Knee Replacement
☐ Lupus
☐ Nervous Disorders
☐ Pregnant
☐ Recovering Addict
☐ Seizures
☐ Sleep Apnea/snore
☐ Thyroid Condition
☐ Tuberculosis

☐ Alcoholism
☐ Allergy-Ibuprofen
☐ Allergy-Percocet
☐ Angina
☐ Asthma
☐ Birth control
☐ Cancer
☐ Cholesterol
☐ Diabetes
☐ Fracture
☐ Headaches
☐ Hepatitis A-B or C
☐ Hypertension
☐ Laryngectomy
☐ Lymphoma
☐ Osteopenia
☐ Psychiatric Care
☐ Respiratory/COPD
☐ Shortness of breath
☐ STD's
☐ TMJ
☐ Tumors

☐ Allergy-Antibiotic
☐ Allergy-Iodine
☐ Allergy-Sulfa
☐ Anxiety
☐ Autoimmune Disorders
☐ Blood Disorder
☐ Cellulitis
☐ Circulatory Problems
☐ Drug Abuse/Addiction
☐ gastroparesis
☐ Heart Disease
☐ High cholesterol
☐ Jaw Pain
☐ Liver Condition
☐ Mental Disorders
☐ Osteoporosis
☐ R/A Cad (stents)
☐ Rheumatic Fever
☐ Sinus Condition
☐ Stroke
☐ Tobacco/Smokes
☐ Ulcers/Reflux/GERD

☐ Allergy-Asprin
☐ Allergy-LocalAnesthe
☐ Alzheimers Disease
☐ Arthritis/Gout
☐ Back Problems
☐ Blood Pressure-High
☐ Chemical Dependency
☐ Cold sores/herpes
☐ Epilepsy
☐ Glaucoma
☐ Heart Murmur
☐ HIV/AID'S
☐ Kidney Disease
☐ Lung Cancer
☐ Migraines/Seizure
☐ Other
☐ Radiation/Chemo
☐ Rheumatism
☐ Skin Rash
☐ Sulfa
☐ Tonsillitis
☐ Weight Fluctuations

☐ Recent hospitalization (illness or injury)
☐ Tobacco Use- Smoke, Vape or Chew
☐ Chemical Dependency
☐ Cough that produces blood

☐ Recreational use of drugs
☐ Alcohol Dependancy
☐ Persistant cough greater then 3 weeks
☐ Been exposed to anyone with Tuberculosis

Physician Name and Phone Number:

Pharmacy Name and Phone Number

If any conditions or alerts selected above need further clarification, please describe below:

Women Only

Please select all the apply:

- ☐ Currently Pregnant
- ☐ Currently Nursing
- ☐ Currently taking Birth Control
- ☐ Trying to get pregnant(Invitro)
- ☐ Hormone Replacement Therapy

Due Date ?

Bone Density Treatment

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer? If yes treatment began

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax?) or risedronate (Actonel?) for osteoporosis or Paget's disease?

○ Yes ○ No

Do you take antibiotic premedication for your dental visits? * * ○ Yes ○ No

Please explain your need to premedicate:

Sleep Related Questions

Please check all that apply:

- ☐ Snore Loudly
- ☐ You stop breathing, choke or gasp during your sleep
- ☐ Feel fatigued or sleepy during the daytime
- ☐ Currently use CPAP

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

Are you taking or have recently taken prescription or over the counter medication, vitamins, or supplements? (please hit return after each entry) * *

○ Yes ○ No

Please list any medications you are currently taking, one medication per line:

Dental History

Previous Dentist Name and Phone Number:

Date of most recent dental exam and dental x-rays:

Please rate your level of fear when visiting the dentist on a scale of 1-10, 10 being extreme _____

Please rate your satisfaction with your smile on a scale of 1-10, 10 being extremely satisfied _____

Ideally I would like to keep all of my natural teeth ◯ Yes ◯ No

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

What is the reason for your dental visit today?

Is there anything about the appearance of your smile that you would like to change?

Please check all that apply to your dental routine:

- ☐ I have my teeth professionally cleaned two or more times per year
- ☐ I have routine dental exams two times per year
- ☐ I floss my teeth daily
- ☐ I have an advanced oral cancer screening annually
- ☐ I have dental radiographs annually
- ☐ None of the above

Please check all that apply:

- ☐ Gums bleed when you brush or floss
- ☐ Food gets trapped in spaces
- ☐ Bad mouth odor
- ☐ Have/had loose teeth
- ☐ Have broken fillings
- ☐ Missing teeth
- ☐ Teeth sensitive to cold, hot, sweets or pressure
- ☐ Experience Dry Mouth
- ☐ Periodontal(gum) treatment
- ☐ Orthodontic treatment(braces)
- ☐ Had any problems associated with previous dental treatment
- ☐ Drink bottled or filtered water
- ☐ Currently experiencing dental pain or discomfort
- ☐ Have/had earaches, or neck pain
- ☐ Have any clicking, popping, or discomfort in the jaw
- ☐ Brux or grind your teeth
- ☐ Have/had sores or ulcers in your mouth
- ☐ Wear dentures or partials
- ☐ Have/had a serious injury to your head or mouth

If any of the checked boxes need further explanation, please describe:

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

Cancellation Policy

A cancellation fee of $100.00 may be assessed to your account for a missed reservation or rescheduling your reserved time without a 48 hour notification within our business hours. Leaving a message does not meet the requirements. If there are unusual circumstances surrounding the need to change a scheduled appointment, please speak directly with a team member.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Cancellation Policy**

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangement must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangement are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he/she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms and will credit any payments to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements have been made

I understand that any fee estimate for this dental care can only be extended for a period of three months from the date of the patient examination.

I agree to pay the charges for the services at the time of treatment. I further agree to pay all costs and reasonable attorney fees if collection agencies are required to collect any unpaid balance for the services performed.

Your signature below acknowledges an understanding that you will be responsible for any additional costs that will not be covered by your insurance plan.

By signing below, you are authorizing our office and its representatives to call you at any number you provided, including mobile or similar devices for any lawful purpose. You agree to any fees or charges that may be incurred for any incoming calls from us, and or/outgoing call to us, to or from any such number without reimbursement from us.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the AdministrationForm.**