

Patient Information

DO YOU HAVE ANY SECONDARY DENTAL INSURANCE? __Yes __No

Confidential

If yes, please ask for a second form.

	WE WOULD LIKE TO C	GET TO KNOW	V YOU BETTER	! DATE			
Legal Name	Preferred Name						
Address		State	Zip				
Home Phone	Cell Phone			Work			
Preferred method of contact:	Home Phone	Cell	Text	Email			
DATE OF BIRTH	Marital Status:	Married	SingleDiv	orcedSeparated	Widowed		
E-mail	Whom n	nay we thanl	c for referring	/ou?			
PERSON RESPONSIBLE FOR DE	ENTAL INVESTMENT						
NAME	Relatio	nship to Pt					
Patient Employer (Parent Emp	loyer, if minor)			Phone	я		
Person to Contact in Case of E	mergency			Phone			
	Dental Insura	nce Info	rmation				
Name of Policy Holder			Relation	nship to Pt			
Policy Holder Soc. Sec. #			Insured Birth	date			
Group Number		Poli	cy ID Number_				
Employer or Ins Group Name_				Phone #			
Insurance Co Name				Phone #			

MEDICAL HISTORY

Are you under a physician's care now? Are you under a physician's care now? Are you uver been hospitalized or had a major operation? No Yes Please explain: Are you ever had a serious head or neck injury? No Yes Please explain: Are you taking any medications, pills, or drugs? No Yes Please explain: Are you taking any medications, pills, or drugs? No Yes Please explain: Do you take, or have you taken, Phen-Fen or Redux? No Yes Please explain: No Yes Please explain: Do you use tobacco? No Yes Please explain: Do you use, or have you had, any of the following? Albelmen's Disease Yes No Contisone Medicine Yes No Hepatitis A Yes No Renal Dialysis Yes No Hapatitis Do Yes No Hapatitis A Yes No Renal Dialysis Yes No	PATIENT NAME				Birth	Date_					
Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you lave, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the problems that you were the problems that you taking any medications, pills, or drugs? No Yes Please explain: No Yes No Renal Dialysis of Renal Yes No Renal Dialysis Please Pleas	Primary Physicain							P	none		
lave, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering to illowing questions. Are you under a physician's care now? Ave you under a physician's care now? Ave you were had a serious head or neck injury? No Yes Please explain: Are you taking any medications, pills, or drugs? No Yes Please explain: Ave you taken, Phen-Fen or Redux? No Yes Please explain: Ave you taken, Somiva, Actonel or meds with bisphosphonates? Yes No Take you taken Fosomax, Boniva, Actonel or meds with bisphosphonates? Yes No Ave you on septical diet? No Yes Please explain: N	Orthopedic and/or Hear	t Doct	or					Ph	ione		
Have you verk been hospitalized or had a major operation? No Yes Please explain: Are you taking any medications, pills, or drugs? No Yes Please explain: Are you taking any medications, pills, or drugs? No Yes Please explain: Do you take, or have you taken, Phen-Fen or Redux? No Yes Please explain: Do you take fosonnax, Boniva, Actonel or meds with bisphosphonates? Yes No Are you on a special diet? No Yes Please explain: Do you use tobacco? No Yes Please explain: Do you use tobacco? No Yes Please explain: Women: Are you Pregnant/Trying to get pregnant? No Yes Taking oral contraceptives? No Yes Nursing? No Yes Are you allergic to any of the following? Applyin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Sulfa Drugs Other: Do you have, or have you had, any of the following? Alzheimer's Disease Yes No Diabetes Yes No Hemophilia Yes No Renal Dialysis Yes No Hepatits Bar C Yes No Renal Dialysis Yes No Hepatits Bar C Yes No Renal Dialysis Yes No Brughdidion Yes No Hepatits Bar C Yes No Renal Dialysis Yes No Employeen Yes No Hepatits Bar C Yes No Scarlet Fever Yes No Employeen Yes No Employeen Yes No Hepatits Bar C Yes No Scarlet Fever Yes No Employeen Yes No Hepatits Bar C Yes No Scarlet Fever Yes No Employeen Yes No Hepatits Bar C Yes No Scarlet Fever Yes No Employeen Yes No Hepatits Bar C Yes No Scarlet Fever Yes No Excessive Bledding Yes No Hepatits Bar C Yes No Scarlet Fever Yes No Excessive Bledding Yes No Hepatits Bar C Yes No Scarlet Fever Yes No Scarlet Fever Yes No Heart Marked Yes No Excessive Bledding Yes No Hepatits Bar C Yes No Scarlet Fever Yes No Heart Marked Yes No Excessive Thirst Yes No Intergular Heartbeat Yes No Spina Biffida Yes No Excessive Thirst Yes No Intergular Heartbeat Yes No Spina Biffida Yes No Excessive Thirst Yes No Heart Murmur Yes No Gental Herpes Yes No Heart Murmur Yes No Parinty Spill-Biozofesse Yes No Heart Murmur Yes No Heart Prolubel Disease Yes No Heart Murmur Yes No Heart Prolubel Disease Yes No Heart Murmur Yes No Heart Prolubel Disease Yes No Heart Mu	Although dental person nave, or medication that yo ollowing questions.	nel prin ou may	narily to be tak	reat the area in and arouing, could have an impo	und you rtant int	r mout errelat	h, your mouth is a part ionship with the dentist	of your e	entire be	ody. Health problems that ve. Thank you for answer	you may
Have you verk been hospitalized or had a major operation? No Yes Please explain: Are you taking any medications, pills, or drugs? No Yes Please explain: Do you take, or have you taken, Phen-Fen or Redux? No Yes Please explain: Do you take, or have you taken, Phen-Fen or Redux? No Yes Please explain: Do you use tobacco? No Yes Please explain: Do you use tobacco? No Yes Please explain: Do you use tobacco? No Yes Please explain: Women: Are you Pregnant/Trying to get pregnant? No Yes Taking oral contraceptives? No Yes Nursing? No Yes Are you allergic to any of the following? Asplrin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Sulfa Drugs Other: Do you have, or have you had, any of the following? Albeimer's Disease Yes No Diabetes Yes No Hemophilia Yes No Renal Dialysis Yes No Hempstis B or C Yes No Renal Dialysis Yes No Hepatitis B or C Yes No Renal Dialysis Yes No Hepatitis B or C Yes No Renal Dialysis Yes No Enghysema Yes No Hepatitis B or C Yes No Scarlet Fever Yes No Epilepsy or Seizures Yes No Hepatitis B or C Yes No Scarlet Fever Yes No Epilepsy or Seizures Yes No Hives or Rash Yes No Scarlet Fever Yes No Excessive Tirist Yes No Intergolated Typoglycemia Yes No Scarlet Fever Yes No Excessive Tirist Yes No Intergolated Typoglycemia Yes No Spina Biffide Yes No Excessive Tirist Yes No Intergolated Typoglycemia Yes No Spina Biffide Yes No Excessive Tirist Yes No Intergolate Heatchest Yes No Sinkle Cell Diaease Yes No Since Diaease Yes No Finding Spells/Dizzines Yes No Heat Mummur Yes No Genital Herpes Yes No Heat Mummur Yes	Are vou under a physician	's care	now?		No	Yes	Please evolain:				
Have you ever had a serious head or neck injuny? Are you taking any medications, pills, or drugs? No Yes Please explain: Do you take, or have you taken, Phen-Fen or Redux? No Yes Please explain: Do you taken Fosomax, Boniva, Actonel or meds with bisphosphonates? No Yes Please explain: Do you use tobacco? No Yes Please explain: Do you use controlled substances? No Yes Please explain: Do you use controlled substances? No Yes Please explain: No Yes No Renal Dialysis Yes No Renal Dialysis No No Renal Dialysis No Yes No Renal Dialysis No No Ren				a major operation?		Yes	Please explain:				
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Do you take, or have you taken, Phen-Fen or Redux? No Yes Have you taken Fosomax, Boniva, Actonel or meds with bisphosphonates? Yes No Are you on a special diet? No Yes Please explain: Do you use tobacco? No Yes Please explain: Do you use controlled substances? No Yes Please explain: Women: Are you Pregnant/Trying to get pregnant? No Yes Taking oral contraceptives? No Yes Nursing? No Yes Are you allergic to any of the following? AspirinPenicillinCodeineAcrylicMetalLatexLocal Anesthetics Sulfa DrugsOther: Do you have, or have you had, any of the following? AlDSi-Hiv Positive Yes No Cortisone Medicine Yes No Hemophilia Yes No Renal Dialysis Yes Alzheimer's Disease Yes No Diabetes Yes No Hepatitis B or C Yes No Rheumatic Fever Yes Anaphylaxis Yes No Easily Winded Yes No Hepatitis B or C Yes No Scarle Fever Yes Anaphylaxis Yes No Easily Winded Yes No Hepatitis B or C Yes No Scarle Fever Yes Anthritis(Jout Yes No Epilepsy or Setzures Yes No High Blood Pressure Yes No Sickle Cell Disease Yes No Excessive Ehlerding Yes No High Blood Pressure Yes No Sickle Cell Disease Yes No Excessive Ehlerding Yes No Herogular Heartbeat Yes No Sinus Trouble Yes No Frequent Diarrhea Yes No Inguilated Yes No Frequent Diarrhea Yes No Inguilated Yes No Spina Billida Yes No Frequent Diarrhea Yes No Investigation Yes No Investigation Yes No Investigation Yes No Investigation Yes No Spina Billida Yes No Stroke Yes No Frequent Headaches Yes No Investigation Yes No Typrod Disease Yes No Tomstillis Yes No Heart Proceeding Yes No Heart Proceeding Yes No Typrod Disease Yes No Tomstillis Yes No Televation Yes No Heart Proceeding Yes No Leukemia Yes No Stroke Yes No Televation Yes No Heart Hazauf-Failure Yes No Real Disease Yes No Yes No Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No Yes No Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No Yes No Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No Yes No Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No Yes No Yes						Vec	Please list:				
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Are you on a special diet? No Yes Please explain: Do you use tobacco? No Yes Please explain: Women: Are you Pregnant/Trying to get pregnant? No Yes Taking oral contraceptives? No Yes Nursing? No Yes Are you allergic to any of the following? AspirinPenicillinCodeineAcrylicMetalLatexLocal Anesthetics Sulfa DrugsOther: Do you have, or have you had, any of the following? AlbShIN Positive Yes No Cortisone Medicine Yes No Hemophilia Yes No Renal Dialysis Yellowing Yes No Diabetes Yes No Hepatitis A Yes No Rheumatic Fever Yes No Hapatitis B or C Yes No Rheumatic Fever Yes No Hepatitis B or C Yes No Rheumatic Fever Yes No Hepatitis B or C Yes No Rheumatic Fever Yes No Hepatitis B or C Yes No Rheumatic Fever Yes No Hepatitis B or C Yes No Rheumatic Fever Yes No Hepatitis B or C Yes No Rheumatic Fever Yes No Hepatitis B or C Yes No Rheumatics Pever Yes No Hepatitis B or C Yes No Rheumatics Pever Yes No Hepatitis B or C Yes No Rheumatics Pever Yes No Hepatitis B or C Yes No Rheumatics Pever Yes No High Blood Pressure Yes No Sinche Cell Disease Yes No High Blood Pressure Yes No Sinche Cell Disease Yes No High Blood Pressure Yes No Sinche Cell Disease Yes No High Blood Pressure Yes No Sinche Prequent Cough Yes No High Problems Yes No Sinche Million Yes No Frequent Diarrhaa Yes No Leukemia Yes No Sinche Yes No Hopatitis Problems Yes No Sinche Prequent Diarrhaa Yes No Leukemia Yes No Sinche Yes No Hearth Mark Yes No Findent Headaches Yes No Low Blood Pressure Yes No Tumors or Growths Yes No Hearth Mark Yes No Findent Headaches Yes No Low Blood Pressure Yes No Tumors or Growths Yes No Hearth Mark Yes No Partityrol Disease Yes No Tumors or Growths Yes No Partityrol Disease Yes No Tumors or Growths Yes No Partityrol Disease Yes No Tumors or Growths Yes No Partityrol Disease Yes No Veneral Disease Yes No Veneral Disease Yes No Heart Pace Maker Yes No Real Mark Yes No Partityrol Disease Yes No Veneral Disease Yes No Veneral Disease Yes No Heart Pace Maker Yes No Real Mark Yes No Partityrol Disease	Do you take, or have you t	aken, F	hen-F	en or Redux?	No	Yes					—
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Are you allergic to any of the following? Aspirin	Do you use controlled sub	stances	?		No	Yes	Please explain:				
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Arthritis/Gout Yes No Epilepsy or Seizures Yes No Hives or Rash Yes No Sickle Cell Disease Yes Arthricial Heart Valve Yes No Excessive Bleeding Yes No Hypoglycemia Yes No Sinus Trouble Yes Artificial Joint Yes No Excessive Thirst Yes No Irregular Heartbeat Yes No Spina Bifida Yes Asthma Yes No Fainting Spells/Dizziness Yes No Kidney Problems Yes No Stroke Yes No Stroke Yes No Frequent Cough Yes No Leukemia Yes No Stroke Yes Blood Disease Yes No Frequent Diarrhea Yes No Liver Disease Yes No Swelling of Limbs Yes Breathing Problem Yes No Frequent Headaches Yes No Low Blood Pressure Yes No Thyroid Disease Yes No Galaucoma Yes No Mitral Valve Prolapse Yes No Tumors or Growths Yes No Hay Fever Yes No Mitral Valve Prolapse Yes No Tumors or Growths Yes Cold Sores/Fever Blisters Yes No Heart Murmur Yes No Parathyroid Disease Yes No Ulcers Yes No Heart Pace Maker Yes No Radiation Treatments Yes No Yellow Jaundice Yes No Recent Weight Loss Yes No Heave you ever had any serious illness not listed above? No Yes Please explain: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be	Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes
Artificial Heart Valve Yes No Excessive Bleeding Yes No Hypoglycemia Yes No Sinus Trouble Yes Artificial Joint Yes No Excessive Thirst Yes No Irregular Heartbeat Yes No Spina Bifida Yes Ashma Yes No Fainting Spells/Dizziness Yes No Kidney Problems Yes No Stomach/Intestinal Disease Yes No Frequent Cough Yes No Leukemia Yes No Stomach/Intestinal Disease Yes No Frequent Diarrhea Yes No Leukemia Yes No Stroke Yes No Stroke Yes No Frequent Diarrhea Yes No Low Blood Pressure Yes No Swelling of Limbs Yes Breathing Problem Yes No Frequent Headaches Yes No Low Blood Pressure Yes No Thyroid Disease Yes No Tonsillitis Yes Cancer Yes No Glaucoma Yes No Mitral Valve Prolapse Yes No Tonsillitis Yes Cancer Yes No Glaucoma Yes No Mitral Valve Prolapse Yes No Tuberculosis Yes Chest Pains Yes No Heart Attack/Failure Yes No Parathyroid Disease Yes No Ulcers Yes Cold Sores/Fever Blisters Yes No Heart Murmur Yes No Psychiatric Care Yes No Yellow Jaundice Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No Yellow Jaundice Yes No Poyou take or have you ever taken antibiotic premedication for dental work? No Yes If yes, why and what antibiotic? To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be	The state of the s									COLD WATER CONTROL OF THE CONTROL OF THE COLD WATER CONTROL OF THE COLD WATER CONTROL OF THE COLD WATER CONTROL OF THE CONTROL OF	Yes
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Do you take or have you ever taken antibiotic premedication for dental work? No Yes If yes, why and what antibiotic? Have you ever had any serious illness not listed above? No Yes Please explain: Comments: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be	Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes
Have you ever had any serious illness not listed above? No Yes Please explain:	Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No		
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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be	Have you ever had any se	rious illı	ness n	ot listed above?	No	Yes	Please explain:				
	Comments:										
dangerous to my (or patient's) nealth. It is my responsibility to inform the dental office of any changes in medical status.											n be
SIGNATURE OF PATIENT, PARENT, or GUARDIANDATEDATE		•									

PATIENT DENTAL HISTORY

Previous Dentist and Location	Date of last Exam
Please list problems concerns	
Do your gums bleed while brushing or flossing?YesNo	
Are your teeth sensitive to hot or cold liquids/foods?YesNo	
Do you feel pain in any of your teeth?YesNo	
Do you have any sores or lumps in or near your mouth?YesNo	
Have you had any orthodontic treatment?YesNo When?	
Have you had any of the following problems in your jaw? Clicking	ng Pain (joint, ear, side of face)
Difficulty in opening or closingDifficulty in chewing OTHE	R:
Do you wear dentures or partials?YesNo If yes, date of place	ement
Do you have trouble sleeping due to snoring?YesNo	
Do you have frequent headaches?YesNo	
Do you bite your lips or cheeks frequently?YesNo	
Have you had difficult extractions in the past?YesNo	
Have you had prolonged bleeding after extractions?YesNo	
Can you wiggle your ears?YesNo	
Do you like your smile?YesNo	
Would you like for your teeth to be straighter?YesNo White	er?YesNo
Other?	



SEDONA DENTAL ARTS

Office Policies and Financial Agreement

Treatment is to be paid in full at the time services are rendered unless other arrangements have been discussed and finalized. We accept Cash, Check, Master Card, Visa, Discover, and CareCredit.

We do not want finances to be an issue for our patients. We understand that it is not always possible to pay for treatment needs in full so we also have the following financial options:

We offer half down at time of service with the balance paid over three months with a credit card on file.

If you need terms more flexible we offer financing with CareCredit with payment over 6 months INTEREST FREE or longer term plans with a budget friendly payment.

FOR THOSE FORTUNATE TO HAVE DENTAL INSURANCE

We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. We will always recommend treatment based upon your dental needs, not based on insurance coverage, which can be inadequate with some dental plans. Dental insurance is a benefit used to assist you, not to dictate necessary treatment. All charges incurred for any treatment that is provided are your responsibility regardless of your insurance coverage. An **estimate** of the amount due from you will be calculated when the appointment is scheduled. As we work with you to reach your optimum oral health, we do require that the estimated co-payment for treatment be paid at the time of service. This is the portion of our fees that your insurance coverage does not assist you with. We encourage you to understand your dental policy and what it covers. Timely payment of patient estimated co-payments ensure that we can keep our administrative costs low, resulting in lower fees for our patients.

Our office strives to be "insurance friendly". Completing insurance forms is a courtesy we extend for your convenience in an effort to save you time and facilitate payment to our practice from your insurance company. We will accept an assignment of benefits from your insurance company (if they allow it) however it is important to understand that the agreement regarding your dental benefits is between you, your employer, and your insurance company. Although we are willing to submit dental claims on your behalf, we do not accept responsibility for the outcome of the transaction. Our practice does not guarantee that your insurance company will assist you with payment for your treatment. If your claim is denied, you will be responsible for paying the full amount not covered. Our practice will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation required by your insurance company. We are happy to assist you but

ultimately it is your responsibility to resolve any type of dispute over payments made or not made by your insurance company to our practice.

LATE ARRIVALS AND CANCELATIONS

We respect our patient's schedules and we ask that you would also have respect for our schedule and the schedule of others. Late arrivals cause us to run late for other patients. Please understand that arriving after your appointment time may result in the rescheduling of your appointment. We do understand unexpected events and emergencies can happen. If it does not interfere with other patient's schedule we will be happy to accommodate you. Please let our office knows as soon as possible that you cannot make your appointment time. We reserve chair time just for you when you make an appointment with us. We do ask for 48 hours' notice to reschedule or cancel an appointment. Multiple rescheduled or cancelled appointments may result in additional charges that would need to be paid prior to scheduling future appointments. The minimal charge for lack of notice will be \$50 or an hourly rate to help defer some of the overhead expense associated with not having a patient scheduled in your time slot. Thank you for your understanding and the consideration of others. After two broken or missed appointments, the dentist reserves the right to discontinue any additional treatment.

AUTHORIZATION AND RELEASE:

I certify that I have read and understand the above information to the best of my knowledge. I understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I authorize Sedona Dental Arts to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payor and/or health practitioners.

MY SIGNATURE ACKNOWLEDGES THAT:

will be responsible to update	ny information on these	forms with each denta	al visit as needed
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I understand the office policy regarding Appointments and Insurance.

I understand and will comply with the office Financial Policy.

I assign my insurance benefits (if applicable) payable to Sedona Dental Arts.

I authorize the Release of Information.

I have been offered a copy of this office's Notice of Privacy Practices as required by the HIPAA privacy regulations.

SIGNATURE OF PATIENT OR LEGAL GAURDIAN	DATE