Sedona DENTAL ARTS

Patient Information Confidential

WE WOULD LIKE TO GET TO KNOW YOU BETTER! DATE_____

Legal Name_____Preferred Name_____

Address_____City_____State_____Zip_____

Home Phone_____Cell Phone_____Work_____

Preferred method of contact: Home Phone_____ Cell_____Text_____ Email_____

DATE OF BIRTH_____ Marital Status: __Married __Single __Divorced __Separated __Widowed

E-mail_____**Whom may we thank for referring you?**_____

PERSON RESPONSIBLE FOR DENTAL INVESTMENT

NAME_____Relationship to Pt_____

Patient Employer (Parent Employer, if minor)_____Phone_____

Person to Contact in Case of Emergency_____Phone_____

Dental Insurance Information

Name of Policy Holder_____Relationship to Pt_____

Policy Holder Soc. Sec. #_____Insured Birthdate_____

Group Number_____Policy ID Number_____

Employer or Ins Group Name_____Phone #_____

Insurance Co Name_____Phone #_____

DO YOU HAVE ANY SECONDARY DENTAL INSURANCE? __Yes __No If yes, please ask for a second form.

MEDICAL HISTORY

PATIENT NAME _____ Birth Date_____

Primary Physicain_____Phone_____

Orthopedic and/or Heart Doctor_____Phone_____

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 may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? No Yes Please explain: _____
Have you ever been hospitalized or had a major operation? No Yes Please explain:_____
Have you ever had a serious head or neck injury? No Yes Please explain:_____
Are you taking any medications, pills, or drugs? No Yes Please list: _____
_____
_____
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?
___Aspirin ___Penicillin ___Codeine ___Acrylic ___Metal ___Latex ___Local Anesthetics
___Sulfa Drugs ___Other:_____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

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 dangerous to my (or patient's) health. **It is my responsibility to inform the dental office of any changes in medical status.**

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

PATIENT DENTAL HISTORY

Previous Dentist and Location_____ Date of last Exam_____

Please list problems concerns_____

Do your gums bleed while brushing or flossing? __Yes __No _____

Are your teeth sensitive to hot or cold liquids/foods? __Yes __No _____

Do you feel pain in any of your teeth? __Yes __No _____

Do you have any sores or lumps in or near your mouth? __Yes __No_____

Have you had any orthodontic treatment? __Yes __No When?_____

Have you had any of the following problems in your jaw? __ Clicking __Pain (joint, ear, side of face)

__Difficulty in opening or closing __Difficulty in chewing OTHER:_____

Do you wear dentures or partials? __Yes __No If yes, date of placement_____

Do you have trouble sleeping due to snoring? __Yes __No _____

Do you have frequent headaches? __Yes __No _____

Do you bite your lips or cheeks frequently? __Yes __No _____

Have you had difficult extractions in the past? __Yes __No _____

Have you had prolonged bleeding after extractions? __Yes __No _____

Can you wiggle your ears?___Yes___No_____

Do you like your smile? __Yes __No_____

Would you like for your teeth to be straighter? __Yes __No Whiter? __Yes __No

Other?_____

THANK YOU! WELCOME TO OUR OFFICE!

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:

I will be responsible to update any information on these forms with each dental visit as needed.

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**