



4530 E. Ray Rd. #170  
Phoenix, Arizona  
Phone 480-940-4321 Fax 480-940-3322

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available.

Date \_\_\_\_\_

**PATIENT INFORMATION**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex M / F  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Social Security \_\_\_\_\_  
Previous address (If less than 1 year above) \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Check appropriate box:  Minor  Single  Married  Divorced  Widowed

If patient is a student, Name of School/College \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**RESPONSIBLE PARTY**

Name of person responsible for the patient's account \_\_\_\_\_

Responsible Person currently a patient in our office:  Yes  NO Social Security \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If different from above

Date of Birth \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

**INSURANCE INFORMATION**

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Group Number \_\_\_\_\_ Insurance effective date \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ Maxiumum Annual Benefit \_\_\_\_\_ Used any this year \_\_\_\_\_

**ADDITIONAL INSURANCE INFORMATION**

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Group Number \_\_\_\_\_ Insurance effective date \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ Maxiumum Annual Benefit \_\_\_\_\_ Used any this year \_\_\_\_\_

## DENTAL HISTORY

Reason for today's visit \_\_\_\_\_ Former Dentist \_\_\_\_\_

Address \_\_\_\_\_ Date of last dental care \_\_\_\_\_ Date of Last x-rays \_\_\_\_\_

Check (✓) if you have had problems with any of the following:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Bad Breath                    | <input type="checkbox"/> Grinding or clenching teeth    | <input type="checkbox"/> Sensitivity to hot        |
| <input type="checkbox"/> Bleeding gums                 | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets     |
| <input type="checkbox"/> Clicking or popping jaw       | <input type="checkbox"/> Periodontal treatment          | <input type="checkbox"/> Sensitivity when biting   |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold            | <input type="checkbox"/> Sores or growths in mouth |

How often do you brush? \_\_\_\_\_ How often do you Floss? \_\_\_\_\_

How do you feel about the appearance of your teeth on scale of 1 to 5? 1(Bad) 2 3 4 5(Great)

Have you ever experienced an adverse reaction during or in conjunction of a dental or medical procedure?  Y  N

## MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Address \_\_\_\_\_ phone \_\_\_\_\_

Date of last visit \_\_\_\_\_ Have you had any serious illness or past operation?  Y  N

If yes describe \_\_\_\_\_

Are you currently under physician care?  Y  N If yes describe \_\_\_\_\_

Have you ever had blood transfusion?  Y  N If yes describe \_\_\_\_\_

Women: are you pregnant?  Y  N Nursing?  Y  N Taking birth control pills?  Y  N

Check (✓) if you have had problems with any of the following:

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> AIDS                    | <input type="checkbox"/> Chemotherapy         | <input type="checkbox"/> Heart murmur                  | <input type="checkbox"/> Material allergies        |
| <input type="checkbox"/> Anaphylaxis             | <input type="checkbox"/> Circulatory problems | Describe _____   | (latex, wool, metal, chemical)                     |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cortisone treatments | <input type="checkbox"/> Bleeding                      | <input type="checkbox"/> Mitral valve prolapse     |
| <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Cough, persistent    | <input type="checkbox"/> Herpes                        | <input type="checkbox"/> Nervous problems          |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Cough up blood       | <input type="checkbox"/> Hepatitis                     | <input type="checkbox"/> Pacemaker/Heart Surgery   |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> High blood pressure           | <input type="checkbox"/> Psychiatric care          |
| <input type="checkbox"/> Atopic (allergy prone)  | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> HIV positive                  | <input type="checkbox"/> Rapid weight gain or loss |
| <input type="checkbox"/> Back problems           | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Jaw pain                      | <input type="checkbox"/> Radiation treatment       |
| <input type="checkbox"/> Blood disease           | <input type="checkbox"/> Food allergies       | <input type="checkbox"/> Kidney disease or malfunction | <input type="checkbox"/> Respiratory disease       |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Liver disease                 | <input type="checkbox"/> Rheumatic fever           |
| <input type="checkbox"/> Chemical dependency     | <input type="checkbox"/> Headaches            |  | <input type="checkbox"/> Scarlet fever             |

List medications you are currently taking:

List drug allergies if any:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered.

I authorize the use of this 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 they are paid by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Payment is due in full at time of treatment unless prior arrangements have been approved.**