CHOLLA
FAMILY DENTISTRY

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

About You

Name _____
(First) (MI) (Last)

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. I prefer to be called: _____

Birthdate: _____ SS#: _____

Home Address: _____

City: _____ State: _____ Zip: _____

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Phone: _____ Mobile: _____

Work Phone: _____ Email: _____

Employer: _____ Occupation: _____

What is your preferred method of contact? _____

Who may we thank for referring you _____

Other family members seen by us: _____

Responsible Party's Information

His/Her Name: _____
(First) (MI) (Last)

Birthdate: _____ SS#: _____

Employer: _____ Occupation: _____

Home Phone: _____ Mobile: _____

Work Phone: _____ Email: _____

Emergency Contact

In the event of an emergency, who would you like us to contact?

Name: _____

Relationship: _____

Home Phone: _____ Mobile: _____

Work Phone: _____ Email: _____

Dental Insurance

Primary Dental Insurance

Name of Insurance Co.: _____

Address: _____

_____

Phone #: _____

Group #: _____

Insured's Name: _____

Relation: _____

Insured's Birthday: _____ Insured's SS#: _____

Insured's Employer: _____

Secondary Dental Insurance

Name of Insurance Co.: _____

Address: _____

_____

Phone #: _____

Group #: _____

Insured's Name: _____

Relation: _____

Insured's Birthday: _____ Insured's SS#: _____

Insured's Employer: _____

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Medical History

Patient Name: _____ DOB: ____/____/____

Are you currently under the care of a physician? If YES, Name: _____

Physician's Name: _____ Physician's Phone #: _____

Describe your current physical health: ❑ Excellent ❑ Fair ❑ Poor

Do you Smoke or use Smokeless Tobacco? ❑ Yes ❑ No Specify: _____

FOR WOMEN: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No If yes, # of weeks _____ Are you nursing? ❑ Yes ❑ No

❑ Y ❑ N Have you ever taken Boniva or Alendronate (Fosamax)? _____

Are you currently taking any ❑ prescriptions ❑ over the counter drugs ❑ herbal supplements ❑ appetite suppressants?

Do you now or have you ever had any of the following medical conditions?

❑ Y ❑ N Heart Disease / Defect	❑ Y ❑ N Hemophilia	❑ Y ❑ N Osteoporosis / Osteopenia
❑ Y ❑ N Heart Murmur	❑ Y ❑ N Leukemia	❑ Y ❑ N Stomach / Intestinal Disease
❑ Y ❑ N Irregular Heart Beat	❑ Y ❑ N Allergies (Seasonal)	❑ Y ❑ N Ulcers
❑ Y ❑ N Angina / Chest Pain	❑ Y ❑ N Pain in the Jaw	❑ Y ❑ N Convulsions / Seizures
❑ Y ❑ N Heart Attack	❑ Y ❑ N Lung Disease	❑ Y ❑ N Epilepsy
❑ Y ❑ N Heart Failure	❑ Y ❑ N Breathing Problems	❑ Y ❑ N Diabetes - type: _____
❑ Y ❑ N Rheumatic Fever	❑ Y ❑ N Tuberculosis (TB)	❑ Y ❑ N Hypoglycemia
❑ Y ❑ N Mitral Valve Prolapse	❑ Y ❑ N Sinus Problems	❑ Y ❑ N Liver Disease
❑ Y ❑ N Artificial Heart Valve	❑ Y ❑ N Asthma - type: _____	❑ Y ❑ N Hepatitis - type: _____
❑ Y ❑ N Heart Pacemaker	❑ Y ❑ N Emphysema	❑ Y ❑ N Jaundice
❑ Y ❑ N Heart Surgery	❑ Y ❑ N Thyroid Disease	❑ Y ❑ N Kidney Problems
❑ Y ❑ N High Blood Pressure	❑ Y ❑ N Fainting / Dizziness	❑ Y ❑ N Arthritis - type: _____
❑ Y ❑ N Low Blood Pressure	❑ Y ❑ N Cancer	❑ Y ❑ N Drug Use / Addiction
❑ Y ❑ N Blood Disease	❑ Y ❑ N Radiation Treatment	❑ Y ❑ N Alcohol Addiction
❑ Y ❑ N Stroke	❑ Y ❑ N Chemotherapy	❑ Y ❑ N Cold Sores / Fever Blisters
❑ Y ❑ N Bruise Easily	❑ Y ❑ N Artificial Joint: _____	❑ Y ❑ N Nervousness
❑ Y ❑ N Anemia	❑ Y ❑ N AIDS / HIV Positive	❑ Y ❑ N Depression
❑ Y ❑ N Excessive Bleeding	❑ Y ❑ N Autoimmune Disease: _____	❑ Y ❑ N Other: _____

Are you allergic to any of the following?

❑ Y ❑ N Aspirin	❑ Y ❑ N Erythromycin	❑ Y ❑ N Penicillin
❑ Y ❑ N Codeine	❑ Y ❑ N Jewelry / Metals	❑ Y ❑ N Tetracycline
❑ Y ❑ N Dental Anesthetics	❑ Y ❑ N Latex	❑ Y ❑ N Other: _____

❑ Y ❑ N Have you ever been hospitalized or had any major operations? _____

Please list any over-the-counter or prescription drugs that you are currently taking.

Medication	Dosage	Reason for Taking Medication

Patient Signature: _____ Date: _____

Dental History

Why have you come to the dentist today? _____

Are you currently in pain or discomfort with your teeth and/or gums? ❑ Yes ❑ No

How would you describe the condition of your teeth and gums? ❑ Excellent ❑ Fair ❑ Poor

Previous Dentist: Last Visit Date:

Have you had orthodontics? ❑ Yes ❑ No If YES, at what age?

Do you have headaches? ❑ Yes ❑ No If YES, how often?

Questionnaire

❑ Y ❑ N Do you understand the correlation between dental plaque control and the prevention of gum disease?

❑ Y ❑ N Do your gums ever bleed?

❑ Y ❑ N Have you ever been told you have gum disease?

❑ Y ❑ N Do you often feel your breath is not as fresh as it could be?

❑ Y ❑ N Do you grind or clench your teeth?

❑ Y ❑ N Have you ever had pain/discomfort in your jaw joint?

❑ Y ❑ N Do you snore or have you been told you do?

❑ Y ❑ N Do you sleep well? How long? _____

❑ Y ❑ N Would you like to have whiter teeth?

❑ Y ❑ N Would you like your teeth to be straighter?

❑ Y ❑ N Are you unhappy with any silver or discolored fillings?

❑ Y ❑ N Do you have crowns or bridges which are unattractive or unnatural looking?

❑ Y ❑ N Do you sometimes feel uncomfortable with the appearance of your smile?

❑ Y ❑ N Are your teeth crooked or crowded?

❑ Y ❑ N Do you think a more attractive smile would improve your personal and/or professional relationships?

❑ Y ❑ N Are you afraid or anxious to visit the dentist?

❑ Y ❑ N Do you wish that you could feel relaxed at your next dental appointment?

What level of dental care do you think your dental insurance company will cover? ❑ Excellent ❑ Fair ❑ Poor

What level of dental care would you like to have for yourself? ❑ Excellent ❑ Fair ❑ Poor

The information that I have given is correct to the best of my knowledge. I understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

I authorize any photographs or slides to be taken of me during treatment at Cholla Family Dentistry for educational purposes, laboratory fabrication, or internal office use. I fully understand that other dentists, team members, and other patients may view these photos for educational and / or treatment purposes.

Signature: Date:

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

If the patient is less than 18 years of age, a parent or legal guardian must sign.

I, _____, have received a copy of this office's Notice of Privacy Practices
(Please Print Patient's Name)

_____
(Signature of Patient or Parent/Legal Guardian)

_____
(Date)

For Patients who need pre-medication only:
I am authorizing this office to call me and remind me to take my pre-medication before my dental appointment. They may leave a message for me regarding this information at any number that I have supplied to them. They may leave a message on any answering machine, voice mailbox or with whomever answers the telephone. I also authorize this office to remind me of my pre-medication on any postcard reminders that the office will mail to me.

_____
(Signature of Patient or Parent/Legal Guardian)

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
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Patient reviewed Privacy Practices, but elected not to take a copy home
- ❑ Other (Please Specify)

Employee signature: _____ Date: _____

_____

_____

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OUR FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have dual insurance, we are always available to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance. Minors MUST be accompanied by an adult for all treatment.

We accept CASH, CHECKS, VISA, AMERICAN EXPRESS, and MASTERCARD. Financing is also available upon request, prior to treatment.

In most instances, we accept assignment of insurance benefits, in which case your portion of each service is due at the time services are rendered. Those who have dual coverage should discuss their payment plans with the receptionist. If your insurance company pays more than the balance due, we will send a refund check to you immediately.

We will gladly discuss your proposed treatment and answer any questions regarding your insurance.

YOU MUST REALIZE, HOWEVER, THAT:

1. YOUR insurance is a contract between you, your employer, and the insurance company.

2. Our fees are generally considered to fall within the acceptable range by most companies and, therefore, are covered up to the maximum allowance determined by each carrier. This applies only to companies that pay a percentage (such as 50% or 80%) or where "UCR" is defined as Usual, Customary and Reasonable fees for this region; thus, most insurance companies consider our fees Usual, Customary, and Reasonable. However, this statement does not apply to companies that reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard cost-of-care in this area.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

4. Should your insurance take longer than 60 days to pay, we ask that you take care of the balance due and then be reimbursed, if and when we receive the insurance payment.

Returned checks are subject to an **additional $35 fee.**

Missed Appointments. Because office time and materials are reserved for you, a fee may be assessed for a missed appointment not canceled **at least 48 hours in advance.** The first such fee will be $40.00; subsequent fees will be charged at our current hygiene rate. Please help us serve our patients efficiently by keeping your scheduled appointments or giving us as much advance notice as possible of a conflict in your schedule.

We must emphasize that, as dental care providers, our relation is with you, not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the day the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, ***please*** don't hesitate to ask us. **We are here to help you!**

_____ _____

RESPONSIBLE PARTY SIGNATURE **NAME OF PATIENT**

_____ _____

NAME OF RESPONSIBLE PARTY (if different from patient) **DATE**

_____

PRINTED NAME OF RESPONSIBLE PARTY