Dental Registration and History

1 PATIENT INFORMATION

Date_____

SS#/Patient ID#_____

Patient Name_____
Last Name

_____
First Name Middle Initial

Address_____

City_____

State_____Zip _____

E-mail_____

Sex ☐ M ☐ F Age_____

Birthdate_____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you?

_____

2 DENTAL INSURANCE

Who is responsible for this account?_____

Relationship to Patient_____

Insurance Company_____

Group #_____

Is patient covered under additional insurance? ☐ Yes ☐ No

Subscriber's name_____

Birthdate_____ SS#_____

Relationship to Patient_____

Insurance Company_____

Group#_____

3 PHONE NUMBERS

Home (_____)_____ Cell (_____)_____

Work (_____)_____ ext _____

Spouse's Work (_____)_____ ext _____

Best Time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (specify someone who does not live in your household)

Name _____

Relationship _____

Home (_____)_____ Cell (_____)_____

Work (_____)_____ ext_____

Preferred Pharmacy _____

Pharmacy Phone (_____)_____

4 DENTAL HISTORY

Reason for today's visit _____ Former Dentist_____

City/State _____ Date of last dental visit_____ Date of last dental x-rays_____

Place a mark on "yes" or "no" to indicate if you have had any of the following.

	Yes	No
Bad breath	☐	☐
Bleeding gums	☐	☐
Blisters on lips or mouth	☐	☐
Broken fillings or teeth	☐	☐
Chew on one side of mouth	☐	☐
Dental implants	☐	☐
Dry Mouth	☐	☐
Food collecting between teeth	☐	☐
Grind or clench teeth	☐	☐

	Yes	No
Gums swollen or tender	☐	☐
Jaw pain or clicking or popping	☐	☐
Pain around ear	☐	☐
Loose teeth	☐	☐
Orthodontic treatment	☐	☐
Periodontal treatment	☐	☐
Sensitivity to cold	☐	☐
Sensitivity to heat	☐	☐
Sensitivity to sweets	☐	☐

	Yes	No
Sensitivity when biting	☐	☐
Sore muscles of face	☐	☐
Sores or growths in your mouth	☐	☐
Nervous about seeing a dentist	☐	☐
Wear partials or dentures	☐	☐
Would you like nitrous oxide ?	☐	☐

How often do you floss? _____ per day

How often do you brush? _____ per day

TURN OVER

Dental Registration and History

5 HEALTH HISTORY

Physician's Name / Office #_____ Date of last visit_____

Have you ever taken any of the group of drugs collectively referred to as : Yes No

1) "fen-phen" these include combinations of Ionimin, Adipex, Fastin (phentermine), Pondimin (fenfluramine) ☐ ☐
2) Bisphosphonates for bone loss or osteoporosis – Boniva, Fosamax, Evista, Etc. ☐ ☐

Place a mark on "yes" or "no" to indicate if you have had any of the following.

	Yes	No
AIDS/HIV	☐	☐
Alcohol intolerance	☐	☐
Anemia	☐	☐
Arthritis, Rheumatism	☐	☐
Artificial heart valves	☐	☐
Artificial joints	☐	☐
Date of surgery _____		
Asthma or Hay Fever	☐	☐
Back problems	☐	☐
Bleeding abnormally, with extractions or surgery	☐	☐
Blood disease	☐	☐
Cancer	☐	☐
Chemical dependency	☐	☐
Chemotherapy	☐	☐
Circulatory problems	☐	☐
Congenital heart lesions	☐	☐
Cortisone treatments	☐	☐
Cough, persistent or bloody	☐	☐

	Yes	No
Diabetes	☐	☐
Sugar level this morning _____		
Emphysema	☐	☐
Epilepsy	☐	☐
Fainting or dizziness	☐	☐
Head aches	☐	☐
Heart murmur	☐	☐
Heart problems	☐	☐
Hepatitis type _____	☐	☐
Herpes	☐	☐
High blood pressure	☐	☐
Jaw pain	☐	☐
Kidney disease	☐	☐
Liver disease	☐	☐
Low blood pressure	☐	☐
Mitral valve prolapse	☐	☐
Nervous problems	☐	☐
Neurological problems	☐	☐
Pacemaker or Defibrillator	☐	☐
Psychiatric care	☐	☐
Radiation Treatment	☐	☐

	Yes	No
Respiratory disease	☐	☐
Rheumatic fever	☐	☐
Scarlet fever	☐	☐
Seizures	☐	☐
Shortness of breath	☐	☐
Sinus trouble	☐	☐
Skin rash or hives	☐	☐
Stroke	☐	☐
Swollen neck glands	☐	☐
Thyroid problems	☐	☐
Tuberculosis	☐	☐
Tumor or growth	☐	☐
Ulcers	☐	☐
Venereal Disease	☐	☐
Weight loss, unexplained	☐	☐
X-ray exposure at work	☐	☐
Do you wear contact lenses?	☐	☐
WOMEN		
Pregnant? Due date _____	☐	☐
Are you nursing ?	☐	☐

6 MEDICATIONS

List any medications you are taking and why. _____

_____

_____

_____

ALLERGIES

☐ Aspirin ☐ Barbiturates ☐ Codeine ☐ Latex ☐ Local Anesthetic ☐ Penicillin ☐ Sulfa ☐ Ibuprofen

☐ Other _____

7 SIGNATURE

X _____ X _____ _____ _____

Signature (parent if minor) DATE Dr's initails date

I acknowledge I have received a copy of the office **Notice of Privacy Practice** X _____date_____

I acknowledge I have received a copy of the **Dental Materials Fact Sheet** as required by law X _____date_____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

A to Z Dental
6749 W. Bethany Home Rd, Suite 102
Glendale, AZ 85303
(623)849-1356

New Patients
Welcome to A to Z Dental and thank you for choosing us as your provider for primary dental care. Our primary goal is to provide quality dental care which is easily accessible and responsive to you in your time of need. Our staff includes a comprehensive interdisciplinary team of professionals who will consistently strive to exceed your expectations to ensure that your experience with us is as comfortable as stress-free as possible.

Office Hours
Monday 9:00 AM to 6:00 PM
Tuesday & Wednesday 8:00 AM to 5:00 PM
Friday 8:00am to 1:00pm

Payments
Payments are expected the day services are rendered, we do offer financing through CareCredit, please ask our staff for more information. In the event of default of payment, or any balance not covered by the insurance that is over 45 days past due, your account will be turned over to the collection agency. The responsible party will pay all reasonable court cost, attorney fees and/ or collection fees incurred.

Insurance
If you have dental insurance, we will gladly process your forms; however, we request that you pay your established portion when service is rendered. Please remember our contract for payment is with you and not your insurance carrier. We are happy to bill your insurance as a courtesy to you, when you have provided us with your complete insurance information. We allow 45 days from the date of service for payment from an insurance company. After this period, we ask you to become responsible for payment of all unpaid fees.

Records
X-rays, photographs, models of the mouth and/or other diagnostic aids used for an accurate diagnosis/ treatment planning are all property of A to Z Dental. Copies of certain aids are available upon request for a $25.00 fee. Please allow 7 business days for processing of file.

Cancelled/Missed Appointments

We cordially ask our patients to give us over 24 hours of advanced notice for any appointment changes; however, we understand emergencies/sickness may arise. Unless real emergency/sickness, all appointments not rescheduled or cancelled on time will be subject to a $50 cancelation fee. _____ Initial

As a courtesy to you and to the rest of our patients, we ask that everyone arrive on time to their reserved appointment, we have a grace period of 15 minutes, if you arrive after this grace period, we may not able to see you and your appointment will be rescheduled. _____ Initial

Once you miss three appointments without prior notification, we reserve the right to discontinue your appointments. _____ Initial

Patient Name_____ Date_____

Parent/ Guardian Printed name_____ Date_____

Signature_____ Date _____