9150 w. Indian School Rd. Suite 106 Phoenix, AZ 85037

(623) 877-7800

PATIENT INFORMATION

Date: _____

Patient Name: _____
First Middle Last

Address: _____City: _____ Zip Code:_____

Phone: _____ Occupation: _____

Email address: _____

Sex ◯ Male ◯ Female ◯ Other Birthdate: _____ Social Security #: _____

In case of emergency, who should be notified?

Name: _____ Phone: _____

DENTAL INSURANCE

Primary person on the insurance _____
First Middle Last

Primary's Address: _____

Birthdate: _____ Social Security #: _____

Relation to Patient: _____ Employer Name: _____

Name of Dental Insurance: _____Member ID: _____

DENTAL

Reason for today's visit: _____

When was your last dental check-up and cleaning? _____

Rate how you feel about your smile. (not so happy) 1 2 3 4 5 6 7 8 9 10 (my smiles looks amazing)

What can we do to make your smile better? _____

How did you hear about our office? _____

MEDICAL HISTORY

Name of Primary Care: _____

Primary Care's Phone #: _____ Date of Last Visit: _____

Mark (X) if you have or had any of the following:

- o PRE-MED- Amoxicillin
- o PRE-MED- Clindamycin
- o PRE-MED- Other
- o Anxiety, Depression
- o Anemia
- o Arthritis, Rheumatism
- o Artificial Heart Valves
- o Asthma
- o Blood Disease
- o Cancer
- o Chemical Dependency
- o Chemotherapy
- o Circulatory problems
- o Diabetes
- o Epilepsy
- o Fainting
- o Glaucoma
- o Heart Murmur
- o Heart Problems
- o Hepatitis
- o High Blood Pressure
- o Hip REPLACEMENT
- o HIV/AIDS
- o Kidney Disease
- o Knee REPLACEMENT
- o Liver Disease
- o Marijuana use
- o Mitral Valve Prolapse
- o Pacemaker
- o Psychological Disorder
- o Radiation treatment
- o Respiratory Disease
- o Rheumatic Fever
- o Stroke
- o Smoke, Vape
- o Thyroid Problems
- o Tobacco Habit
- o Tuberculosis
- o Venereal Dise

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva.

◯ Yes ◯ No

Do you have any metal parts in your body (piercings excluded)? Examples: plates, artificial joints, hip replacements.

◯ Yes ◯ No

Have you had any serious illness or operations?

◯ Yes ◯ No If yes, please write what it is and what year: _____

Are you pregnant?

◯ Yes ◯ No If yes, how many months?_____

Are you taking any **medication**? ◯ Yes ◯No If yes, please list medication below.	Do you have **allergies** to anything? ◯ Yes ◯ No If yes, please list below.

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Giving Consent

Name: _____ Date of Birth: _____

Please read the following statements carefully.

Purpose of Consent: By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide to sign the consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of uses and disclosures may make of your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions, by contacting:

Center Point Dental 9150 W Indian School Rd. #106 Phoenix, AZ 85037 **Ph. 623-877-7800**

I, _____, have had full opportunity to read and consider the contents of the Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment.

Signature: _____ Date: _____

If patient is a minor or a personal representative is signing this form, please complete the following:

Personal representative's name: _____ Relationship to patient: _____

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Is there any person we can speak with in regards to your dental treatment?

◯ Yes ◯ No If yes, please write their names.

Name	Relationship

FINANCIAL POLICY

I understand that my insurance is an agreement between me and my insurance company. I also understand that I am responsible for my balance regardless of my insurance.

I understand that I may be charged a 1.5% per month or 18% per year finance charge if my balance goes beyond 90 days.

I assign dental benefit payments to be paid directly to Center Point Dental from my insurance company.

I understand that payment or co-payment will be collected at the beginning of each appointment.

I understand that the Treatment Plan Estimate is only an ESTIMATE. Once the insurance company completely process the claim, we will refund or send you a bill if there is any difference in the payment made at the time of service.

OFFICE GUIDELINE

Emergency: For any dental emergency, call our office and leave a detailed message along with your name and phone number. Your call will be returned on the next business day.

Appointments: For any reasons that you need to cancel your appointment, please call at least 24 hours before your scheduled time. We will charge $50 if you do not call to cancel or fail to show up to your scheduled appointment.

Patients, who do not show up for their appointments 3 times without prior notice, will be dismiss from our office.