AZ Family Dental
www.ArizonaFamilyDental.com

8519 N. 59th Ave.
Glendale, AZ 85302
PH: 623.939.6574
Fax: 623.939.3091

PATIENT INFORMATION

Last Name	First Name	Middle	☐ Married	☐ Single	☐ Minor	☐ Male ☐ Female
Address	City	State	ZIP	Birth Date		
SS#	Telephone	Cell	Email			
Employer	Employer Phone	School Name *(If Full-Time Student)*				
If minor, responsible party:	Last Name	First Name	Middle			
Address (if different from above)	City	State	ZIP			

REFERRAL INFORMATION

Whom may we thank for referring you to our practice?	☐ Another Patient - Name:					
☐ Mailer	☐ Google	☐ Website	☐ Facebook	☐ Yellow Pages	☐ Insurance	☐ Other

INSURANCE INFORMATION

Name of Insured			Is insured a patient? ○ Yes ○ No	
Insured's Birth Date	ID#	Group#		
Insured's Address	City	State	ZIP	
Insured's Employer's Name				
Patient's relationship to insured:	☐ Self	☐ Spouse	☐ Child	☐ Other
Insurance Plan Name and Address				

AUTHORIZATION *(All Patients or Guardians must sign)*

I authorize the dentist to perform diagnostic procedures and treatments as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits or credit information. I authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

X _____ _____

Signature of Patient, Parent or Guardian | Date

MEDICAL HISTORY

Are you under a physician's care now? Why? Who?	Phone	○ Yes ○ No
Have you ever been hospitalized or had a major operation? Discuss		○ Yes ○ No
Have you ever had a serious injury to your head or neck? Discuss		○ Yes ○ No
Are you taking any medications, pills or drugs? What?		○ Yes ○ No
Are you allergic to any medications or substances?	☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other	
Women (Please check)	☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives	

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

Have you ever had any illness not checked above? ○ Yes ○ No	Do you smoke? ○ Yes ○ No	How many packs / day?
Do you use any other form of tobacco? ○ Yes ○ No	What Kind?	
Number of sodas or sweet drinks per day	Do you wish to talk to the dentist privately about any problems?	○ Yes ○ No

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ _____

Signature of Patient, Parent or Guardian — Date

_____ _____ _____

Reviewed by Doctor — Date — BP

DENTAL HISTORY

Are any family members current patients? ○ Yes ○ No	Name of previous dentist	
Date of last dental visit	How long since last cleaning?	Reason for changing
Describe any current dental problems		

APPREHENSION

○ Yes ○ No	Do you experience fear of having dental treatment performed? Anything specific?
○ Yes ○ No	Have you had any unpleasant dental experiences?
○ Yes ○ No	Have you ever received laughing gas in a dental office?
○ Yes ○ No	Have you ever received any other kind of sedation for treatment?
○ Yes ○ No	Do you dread the numbing side effects?
○ Yes ○ No	Do you feel you need any help overcoming fear?

YOUR SMILE

○ Yes ○ No	Do you think you have a pretty smile?
○ Yes ○ No	Have you had any cosmetic dentistry?
○ Yes ○ No	Are your teeth crooked? Does this bother you? ○ Yes ○ No
○ Yes ○ No	Do you have any fillings or blemishes on your teeth that look bad?
○ Yes ○ No	Would you like to have whiter teeth?
○ Yes ○ No	Is there anything that you feel could make your smile look better? Please Describe

TEETH PROBLEMS

○ Yes ○ No	Are your teeth sensitive to hot, cold, sweets or pressure?
○ Yes ○ No	Does food regularly wedge between certain teeth?
○ Yes ○ No	Do you have any areas that are hard to floss?

HEADACHES AND FACIAL PAIN

○ Yes ○ No	Do you have frequent headaches?
○ Yes ○ No	Do you experience popping or clicking upon opening or closing?
○ Yes ○ No	Do your jaw or facial muscles ever get tired or sore after chewing, sleeping, stress, etc?
○ Yes ○ No	Do you experience facial muscle pain while chewing or when you wake up?

GUM PROBLEMS

○ Yes ○ No	Do your gums ever bleed when you brush or floss?
○ Yes ○ No	Have your gums receded or pulled away from your teeth?
○ Yes ○ No	Do you have bad breath or bad tastes?

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FINANCIAL POLICY

We at AZ Family Dental would like to welcome you to our practice. Dr. Parker believes in providing quality dentistry that exceeds his patient's expectations. In an effort of full disclosure and transparency, we would like to provide you with the following information to make your experience more enjoyable.

METHODS OF PAYMENT
Payment is expected at time of service. We do accept insurance assignment but the patient portion is due at each visit. We do not send monthly bills.

PLEASE CHECK ONE	☐ Cash	☐ Check	☐ Credit Card (Visa, Mastercard, Discover, Amex)	☐ Care Credit

OFFICE POLICY

Broken Appointments & Cancellations

We at AZ Family Dental schedule our patients for treatment exclusively with the doctor or hygienist at a certain time. We do not "double book" appointments causing our patients a long wait to be seen, therefore we ask that you are on time for your appointments.

Because we reserve time exclusively for you, we have found it necessary to make a written office policy regarding broken appointments and short notice cancellations. We will always make every effort to contact you the day before your appointment as a reminder, but we often must leave you a message.

There will be a $35 charge for cancellations and broken appointments with less than 24 hours notice.

ACKNOWLEDGMENT *(All Patients or Guardians must sign)*

While we are contracted as a preferred provider for many PPO's, we accept all other PPO's as an out-of- network provider. We also accept all traditional indemnity insurance.

Ultimately, you are responsible for payment of all fees for dental care rendered by our office.

I have read and understand the financial policy of AZ Family Dental.

X _____ _____

Signature of Patient, Parent or Guardian — Date

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Notice of Privacy Practices.

You May Refuse to Sign This Acknowledgment

_____ _____

Please PRINT Your Name — Date

X _____ _____

Signature of Patient, Parent or Guardian — Date

ACKNOWLEDGMENT OF PERSONAL REPRESENTATION

I, _____, am the "personal representative" and have legal authority to make health care decisions about the following patient:

_____

Please Print Patient's Name

AUTHORIZATION FOR ADDITIONAL DISCLOSURE

I authorize the following individuals to have access to my health information.

1	Name	Relationship
2	Name	Relationship
3	Name	Relationship

X _____ _____

Signature of Patient, Parent or Guardian — Date

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

_____ Other (Please Specify) _____