

WE WARMLY WELCOME YOU.

To better serve you, please take just a couple of minutes to answer the following questions. Thank you!

Please check any of the following problems that apply to you:

- Sensitivity (hot, cold or sweets)
- Headaches, earaches, neck pain
- Teeth or fillings breaking
- Grinding or clenching teeth
- Bleeding, swollen, or irritated gums
- Loose, tipped, or shifting teeth
- Bad breath

Do you have or have you had any of the following?

- Dentures (How old? _____)
- Partial Dentures (How old? _____)
- Periodontal (gum) treatments (How long ago? _____)

Please share the following approximate dates:

Your last cleaning _____
 Your last oral cancer screening _____
 Your last complete x-rays _____

What are the most important things to you about your smile and dental health? _____

Do you smoke or use chewing tobacco? Yes No

If yes, how much? _____
 And, for how long? _____

If you could change your smile, would you:
 (Please check all that apply)

- Make your teeth whiter
- Make your teeth straighter
- Close spaces between teeth
- Replace black metal fillings with tooth-colored restorations
- Repair chipped teeth
- Replace Missing teeth
- Replace old crowns that don't match
- Have a smile makeover

On a scale of 1 to 5, with 5 being the highest rating:
 (Please circle the numbers that best applies)

How important is your dental health to you?

1 2 3 4 5

How would you rate your current dental health?

1 2 3 4 5

Where do you want your dental health care to be?

1 2 3 4 5

I want to keep my teeth and/or improve my smile, but have certain time and money concerns.

1 2 3 4 5

What is the most important thing to you about your dental visit today? _____



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◆ 602.978.3500
◆ 623.537.5327

Please print clearly

Patient: _____ **Prefers:** _____
Last Name First Name MI

Gender: F / M **Martial Status:** Single / Married / Other **Social Security:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____
What Phone number is best to get a hold of you during the day? _____ Home _____ Cell _____ Work

Address: _____ **City** _____ **State** _____ **Zip** _____

Birth date: _____ **Email:** _____

Drivers License: _____ **Is it ok to send text messages?** Yes No

Emergency Contact Information: _____ Initial (here for us to talk with this person about you and your account.)

Name: _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Home Street Address (if different than above)

Address: _____ **City** _____ **State** _____ **Zip** _____

Relationship to patient: _____

Referral: To whom may we thank for referring you to our practice?

Responsible Party: (if different than patient)

Name: _____

Address: _____ **apt#** _____

City: _____, **State:** _____ **Zip Code:** _____

Phone Number: (_____) _____

Date of Birth: _____

Social Security Number: _____ - _____ - _____

Drivers License Number: _____

Release & Financial Policies :

- Full payments for services are due and payable on the day of my dental visit when treatment is started.
- I understand that all dental services furnished are charged directly to me as the patient regardless of insurance.
- I accept responsibility for past due and unpaid balances including; fees, penalties, interest, court costs and retrieval/posting of credit report information.
- I understand that my dental benefit plan is a contract between me and my insurance company, Arthurs Family Dentistry is not part of that contract.
- I understand that some necessary treatments are not covered benefits under some plans.
- As a courtesy: Arthurs Family Dentistry, llc, will complete and mail my insurance claim forms.
- If your insurance does not accept assignment of benefits full payment will be collected day of appt. Reimbursements are sent to these patients.
- I agree that if my insurance payment comes to Arthurs Family Dentistry, llc and leaves a balance, Arthurs Family Dentistry, llc may charge the remaining balance due to my credit card on file.
- This office has a 48-hour cancellation policy. If the cancellation is made after the 48-hour deadline, Arthurs Family Dentistry, llc reserves the right to charge me a fee for the lost time.
- If a refund is requested, there will be an 8 to 12 week processing timeframe before checks would be received.
- If I was formerly a patient of record with a different dentist, I agree to and understand that all future care will be provided by Arthurs Family Dentistry, llc and its providers and do not hold Arthurs Family Dentistry responsible for any care provided before this date.
- **There will be a \$50 penalty on all returned checks.**

I authorize the dentists and hygienists at Arthurs Family Dentistry, llc to perform diagnostic procedures and treatment as necessary for proper dental care. I authorize and consent to photos and images to be taken and displayed for marketing and/or learning purposes. I hereby authorize 'Assignment of Benefit' by my insurance carrier and the release of any information concerning my (or my family's) health care, advice and treatment provided for the purpose of evaluation. By signing below, I agree to continue accepting financial responsibility for any and all services provided. I also verify that all the information on this form is current and accurate.

x **My initial here acknowledges that, I understand Arthurs Family Dentistry abides by the HIPPA Law and will protect the privacy of my personal information.**

Signature of patient, parent or guardian

Printed Name

MEDICAL HISTORY:

Name: _____ **Date of Birth:** _____

Name of Physician: _____ **Phone:** _____

When was your last physical exam? Date: _____

Please MARK all that apply and CIRCLE the specifics:

Medications: Are you taking any?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Any anticoagulants/Blood thinners.....	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Allergies: Medications, substances or anesthetics	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you have any other allergies?.....	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Are you sensitive to any metals or latex?.....	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Pregnancy: Do you suspect you may be?.....	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Birth control medications?.....	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Heart Health: Are you treated for or advised of Heart disease?.....	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Pacemakers or artificial heart valve implant?.....	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Heart murmurs?.....	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
High blood pressure?.....	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Serious illness: Major surgery?.....	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you have any artificial joint/prosthesis or hardware?.....	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Are you a diabetic?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Rheumatic fever?.....	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have you ever had radiation treatment, chemotherapy?.....	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Tuberculosis?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Dental: Soreness, clicking or popping in your jaw joint?.....	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Ever had any complications following dental treatment?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
General: Do you have stomach problems?.....	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Inflammatory diseases such as arthritis or rheumatism?.....	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you have any kidney problems?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you have any liver problems?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you have asthma?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you or have you had any sexually transmitted diseases?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Blood disorders: Such as anemia, leukemia, etc.....	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
HIV/AIDS?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you test positive for hepatitis?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Excessive bleeding after being cut or injured?.....	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have you ever received a blood transfusion?.....	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you smoke: chew, use snuff or any other forms of tobacco?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Consume alcoholic beverages?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you habitually use controlled substances?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you have any health problems that need further clarification?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

If you marked yes for taking any medication, having any allergies, or any Major surgeries, please list in the appropriate box on the next page.

Medication List: _____

Allergy List: _____

Surgery List: _____

Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

I acknowledge the information in the Medical History to be correct and current.

x _____ Date: _____ Relationship to Patient: _____
 Signature of patient, parent or guardian

 Printed Name of parent or guardian

I have received a copy of Arthurs Family Dentistry's "Our Commitments" form. I have read and thoroughly understand all the statement on the form.

x _____ Date: _____ Relationship to Patient: _____
 Signature of patient, parent or guardian

 Printed Name of parent or guardian

Insurance Information

Employment: (Of Responsible Party)

Patient: _____

Company: _____

Address: _____ City _____ State _____ Zip _____

Phone: _____

Occupation: _____

Insurance Primary plan:

Insured's Name: _____ Date of Birth: _____

Group Name (employer) : _____ Group or Account # _____

Member ID Number: _____

Insurance Company Name: _____

Claims
Address: _____ City _____ State _____ Zip _____

Claims Phone: _____

Insurance Secondary plan

Insured's Name: _____ Date of Birth: _____

Group Name (employer): _____ Group or Account # _____

Member ID Number: _____

Insurance Company Name: _____

Claims
Address: _____ City _____ State _____ Zip _____

Claims Phone: _____



Our Commitments

We feel it is important to share a few policies of our practice with you. We have put them in writing because we live by them and request that our patients live by them as well. We ask that you read this thoroughly to become familiar with them, then sign and date to indicate that you understand and agree to comply with them.

COMMITMENT TO TREATMENT POLICY

We believe that all treatment begun should be completed. Incomplete treatment leads to problems, complications, further disease, and more expenses. Therefore, if a plan is agreed upon and started, it needs to be completed. Rest assured that we would never move forward with treatment without your consent.

COMMITMENT TO APPOINTMENT POLICY

We reserve time for each patient in our practice and rarely keep patients waiting. An appointment written in our schedule with your name on it is a bond of trust that we will be here to serve you and that you will be present for that appointment. Our answering machine does not accept appointment cancellations or changes. We must have mutual respect for each other's time.

COMMITMENT TO FINANCIAL AGREEMENT POLICY

We believe we have a responsibility to you to use our best professional care, skill and judgment in planning and delivering your dental treatment. We can only fulfill this mission through a bond of trust with you to pay for services. We will do our best to make you aware of all fees before treatment is rendered

INSURANCE POLICY

Our office does not diagnose, render treatment or establish fees according to any insurance tables or allowances. Our fees are based on the care, skill and judgment of the professionals delivering the services, and the cost of operating a dental office dedicated to excellence. Please remember that we work 100% for you, not your insurance company. Your dental plan may only cover charges for the least expensive results. **We refuse to compromise our standards by offering anything less than the complete care that you deserve.** Please understand that you are ultimately responsible for any amounts not covered by your plan.

Thank you, we feel honored that you have chosen us to service your dental needs.