OCOTILLO TRAILS
FAMILY DENTISTRY

Welcome to our office!

To serve you the best, please provide the following information – all information is confidential.

Patient Information

Patient Name: _____ **Date:** _____
Last, First MI (Preferred Name)

Social Security #: _____ **Driver's License #:** _____ **Birth Date:** _____

Phone (Home): _____ **(Work):** _____ **(Mobile) Phone:** _____

Email Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

☐ Male
☐ Female
☐ Single
☐ Married
☐ Child

Employer Name: _____ **Occupation:** _____

Employer Address: _____
Street City, State Zip Code

Dental History

What is the reason for your visit today? _____

How do you feel about visiting the Dentist? _____

Date of last dental exam: _____ **Date of last dental cleaning:** _____

Have you ever had any complications with dental treatment? ☐ Yes ☐ No

If yes, please explain: _____

To be completely comfortable, would you prefer to be *sedated* during dental treatment? ☐ Yes ☐ No

If you could change your smile, what would you change?

☐ Straight teeth ☐ Whiter teeth ☐ Close gaps between teeth ☐ Replace missing teeth ☐ Worn teeth
☐ More youthful smile ☐ Replace metal fillings with tooth colored fillings ☐ Restore broken teeth

Do you have any of these concerns:

☐ Bad breath ☐ Cold Sores ☐ Bleeding Gums ☐ Morning headaches ☐ Jaw joint pain
☐ Teeth grinding / clenching ☐ Athletic Sports guard ☐ Receding Gum line ☐ Dry Mouth

Referral Information

Whom may we thank for referring you to our practice?

☐ Another patient, friend ☐ Another patient, relative ☐ Insurance Provider List ☐ Yellow Pages
☐ Postcard ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Patient Name: _____ Birth Date: _____
Last, First MI

Responsible Party Information
(if different from patient)

Name: _____

Social Security #: _____ **Driver's License #:** _____ **Birth Date:** _____

Relationship to the patient: _____

Phone (Home): _____ **(Work):** _____ **Mobile Phone:** _____

Address: _____
Street Apartment #

_____
City State Zip Code

Insurance Information

Name of Insured: _____ **Is insured a patient?** ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Health Information

Have you ever had any of the following? Please check a yes or no to each box:

Yes/No		Yes/No		Yes/No	
☐ ☐	Heart Attack	☐ ☐	Metal / Jewelry allergy	☐ ☐	Nervous Disorders
☐ ☐	Angina	☐ ☐	Stroke	☐ ☐	Epilepsy / Seizures
☐ ☐	High Blood Pressure	☐ ☐	Hepatitis	☐ ☐	Fainting
☐ ☐	Endocarditis	☐ ☐	HIV / AIDS	☐ ☐	Glaucoma
☐ ☐	Artificial Heart Valve	☐ ☐	Tuberculosis	☐ ☐	Radiation Treatment
☐ ☐	Congenital Heart Disease	☐ ☐	Kidney Disease	☐ ☐	Sinus Problems
☐ ☐	Artificial Joints	☐ ☐	Liver Disease	☐ ☐	Asthma
☐ ☐	Diabetes	☐ ☐	Head Injuries	☐ ☐	Cancer
☐ ☐	Thyroid Disease	☐ ☐	Respiratory Problems	☐ ☐	Cigarette Smoking
☐ ☐	Latex Allergy	☐ ☐	Bleeding / Clotting Problems	☐ ☐	Chewing Tobacco
☐ ☐	Penicillin Allergy	☐ ☐	Jaundice	☐ ☐	Anemia
☐ ☐	Other Allergies	☐ ☐	Stomach Problems	☐ ☐	**Pregnancy**
	_____	☐ ☐	Arthritis		Due date:_____

- **Do you have any health problems or conditions or diseases that are not listed above?** ☐ **Yes** ☐ **No**

  If yes, please explain: _____
- **Name of Physician:** _____ **Phone:** _____
- **Please list all medications you are currently taking including all over the counter products:** _____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor before treatment.

_____
Signature of patient, parent or guardian Date Signature of the Doctor

Patient Name: _____ Birth Date: _____
Last, First MI

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Office Policies

Please check all boxes below

Financial Policy Agreement

- ☐ Payment is expected at the time when services are provided. If you have insurance, the estimated patient portion of the fee is due at the time of service. Any other payment arrangement must be made in advance of services.
- ☐ If the insurance company has not fully paid a claim after a reasonable period of time, (usually 30 days) you will be required to pay that remaining portion.
- ☐ As a courtesy, we are happy to verify your benefits and bill your insurance. Information received is not a guarantee of benefits or payment from the insurance company, we use this information to estimate as closely as possible your insurance coverage.
- ☐ I understand that any costs incurred during treatment are my responsibility. I realize that insurance may help pay part of my treatment and that the estimates quoted to me are only *estimates*. I will be responsible for any fees unpaid by the insurance company. I understand that there may be monthly interest (1.5%) applied to the balance, and any additional costs of collection will be applied to the balance.

Cancellation Policy Agreement

- ☐ We provide many ways to notify you of appointments such as a post card, email and text. We require confirmation that you will be here for your appointment which can be done by responding to the email or text which is sent 4-5 days before your appointment. If we have not heard back by any of these methods we will also give a courtesy phone call. We feel these are the most convenient ways of communication but please do notify us if you do not wish to receive an email or text.
- ☐ When an appointment is made we have reserved this time exclusively for you. If you are unable to keep a scheduled appointment we require 2 FULL BUSINESS DAYS notice for any cancellations or changes to your appointment. This gives us sufficient time to offer it to another patient. If we do not receive this courtesy, a fee will be charged up to the amount of the scheduled appointment.

Notice of Privacy Practices Acknowledgement

- ☐ Under the *Health Insurance Portability & Accountability Act of 1996* (HIPAA) I have certain rights to privacy regarding my protected health information. This information is used to conduct to your treatment, obtain payment from third party payers, and other various uses. I acknowledge that I have received your *Notice of Privacy Practices* containing a complete description of the uses of my health information and how I may restrict the use of this information.

Consent for Treatment

- ☐ I give consent for dental treatment by the doctor and staff.
- ☐ I understand that I may ask questions at any time regarding the risks, benefits and alternatives for any recommended treatment.

Signature of patient, parent or guardian	Date	Relationship to Patient
Signature of guarantor of payment/responsible party	Date	Relationship to Patient