Patient Information

Date_____

Patient's Name-Last_____ First_____Middle_____

□ Single □ Married □ Widowed □ Divorced Age_____ Sex: M F Birthdate_____

Address-Street_____City_____State____Zip_____

Home Phone_____ Cell Phone_____ Social Security #_____-_____-_____

Email: _____

Who may we thank for referring you to our office? _____

Responsible Party Information

Name-Last_____First_____Middle_____

Mailing Address-Street_____City_____State_____Zip_____

Home Phone_____Work Phone_____

Email Address_____ Cell Phone _____

Social Security #_____-_____-_____ Birthdate_____

Employer_____Position_____ Phone # _____No. of Yrs Employed_____

Spouse's Name-Last_____First_____Middle_____

Spouse's Employer_____Position_____ Phone # _____No. of Yrs Employed_____

Emergency Contact Information

Please give the name of the nearest relative not living with you:

Name_____Relationship_____ Phone_____

Complete Address_____

Primary Dental Insurance

Policyholder Name _____

Last name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Social Security # _____

Address (if different from patients) _____ Phone Number (___) _____

City _____ State _____ Zip _____

Policyholder Employed by _____ Occupation _____

Business Phone # _____

Insurance Company _____

Social Security # _____ Group # _____ Subscriber # _____

Secondary or Additional Dental Insurance

Policyholder Name _____

Last name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Social Security # _____

Address (if different from patients) _____ Phone Number (___) _____

City _____ State _____ Zip _____

Policyholder Employed by _____ Occupation _____

Business Phone # _____

Insurance Company _____

Social Security # _____ Group # _____ Subscriber # _____

I agree to pay in full at the time of treatment and understand there is a 48 hour notice of cancellation of appointment (a fee of $50 will be charged for each hour scheduled if notice is less than 24 hours). However, should any balance remain after 60 days, I will pay interest at the annual rate of 18% (1.5% per month) starting from the date the charges were made and a $25.00 late payment fee. I understand that delinquent accounts are turned over to a collection agency. If this account is assigned to an outside agency for collection I agree to pay, with or without suit, all attorney fees, court costs, and a collection fee of $50 which will be added to the outstanding balance of my account.

Signature_____ Date_____

Medical History

Physician's Name _____ Date of Last Visit _____

Are you under a physician's care now ☐ yes ☐ no For What: _____

Have you ever been hospitalized or had a major operation? ☐ yes ☐ no For What:_____ When: _____

Have you ever had a serious head or neck injury? ☐ yes ☐ no Explain: _____

_____

Are you taking "Fosamax" or any Osteoporosis Medication? ☐ yes IV or Oral (circle one) ☐ no _____

Are you taking any medications ☐ yes ☐ no Please list all medications & provide dosage _____

_____

Do you use tobacco? ☐ yes ☐ no Are you Pregnant or trying to get pregnant ☐ yes ☐ no

Do you use controlled substances? ☐ yes ☐ no Are you nursing? ☐ yes ☐ no

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other – please explain

_____

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

☐ AIDS/HIV Positive	☐ Congenital Heart Disorder	☐ Hepatitis A	☐ Recent Weight Loss
☐ Alzheimers Disease	☐ Convulsions	☐ Hepatitis B or C	☐ Renal Dialysis
☐ Anaphylaxis	☐ Diabetes	☐ Herpes	☐ Rheumatic Fever
☐ Anemia	☐ Drug Addiction	☐ High Blood Pressure	☐ Rheumatism
☐ Angina	☐ Emphysema	☐ Hives or Rash	☐ Sickle Cell Disease
☐ Arthritis/Gout	☐ Epilepsy or Seizures	☐ Hypoglycemia	☐ Sinus Trouble
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Irregular Heartbeat	☐ Stomach/Intestinal Disease
☐ Artificial Joint	☐ Excessive Thirst	☐ Kidney Problems	☐ Stroke
☐ Asthma	☐ Fainting Spells/Dizziness	☐ Leukemia	☐ Swelling of Limbs
☐ Blood Disease	☐ Frequent Cough	☐ Liver Disease	☐ Thyroid Disease
☐ Blood Transfusion	☐ Frequent Headaches	☐ Low Blood Pressure	☐ Tumors or Growths
☐ Breathing Problem	☐ HPV-Human Papilloma Virus	☐ Lung Disease	☐ Tuberculosis
☐ Bruise Easily	☐ Heart Attack/Failure	☐ Mitral Valve Prolapse	☐ Ulcers
☐ Cancer	☐Heart Murmur	☐ Pain in Jaw Joints	☐ Anxiety
☐ Chemotherapy	☐ Heart Pace Maker	☐ Parathyroid Disease	☐ Osteoporosis
☐ Chest Pains	☐ Heart Trouble/Disease	☐ Psychiatric Care	☐ Cold Sores/Fever Blister
☐ Hemophilia	☐ Radiation Treatments		

Have you ever had any serious illness not listed above ☐ Yes ☐ No If Yes to this or any of the above, please explain

_____

Dental History & Reason for Visit

Reason for today's visit? _____

☐ Emergency(fee for emergency treatment is payable at time of appointment)

Date of last dental care _____Former Dentist _____ Date of last dental x-rays _____

Check (√) if you have had problems with any of the following:

☐ Bad Breath	☐ Grinding Teeth	☐ Sensitivity to hot
☐ Bleeding gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking or Popping Jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food catches between teeth	☐ Sensitivity to cold	☐ Sores or growths in or near mouth

Are you happy with the appearance of your teeth? _____

Have you ever had a bad experience in a dental office? ☐ yes ☐ no Please Explain: _____

_____

Privacy Practices

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You may refuse to sign this acknowledgement

I, _____ (printed name) have received a copy of this office's Notice of Privacy Practices.

Signature: _____ Date: _____

Authorization and Release

I understand and acknowledge that all questions have been accurately answered and that providing incorrect information can be dangerous to my health.

- I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered, to me or my child during the period of such dental care to third party payer's and/or healthcare practitioners.

- I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature: _____ Date: _____

Financial Agreement

Dr. Zachary Davis

We, the undersigned, individually and as agent for the patient, understand and agree, jointly and severally, to the following:

1. That if this account is sent to collections, we agree that in addition to any amount left owing to San Tan Smiles Family Dentistry, we will be responsible for a late fee of $25.00 and interest at the rate of 18% annually on any past due balance, calculated from the date of service, plus court costs and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance, and a collection fee of $50 if my account is assigned to a collection agency.

2. That we specifically authorize San Tan Smiles Family Dentistry or any assignee thereof, to access our credit file should this account become delinquent. We recognize that insurance is a contract between the patient and insurance company, and agree to pay all charges under this agreement regardless of any insurance coverage. This agreement shall apply to any unpaid services owed to San Tan Smiles Family Dentistry and shall remain in effect for future services unless the responsible person notifies San Tan Smiles Family Dentistry in writing that it is to be revoked. We have either received or refused a copy of this agreement. We agree that no oral agreements have been made and that this agreement cannot be modified orally.

3. That we acknowledge that San Tan Smiles Family Dentistry including its attorneys and assigns, may have a legitimate business purpose in calling me to discuss this account and we expressly consent that we may be contacted at any telephone number, including a cellular telephone, by means of an automatic telephone dialing system or an artificial or prerecorded voice, or by a live caller, and that we will bear the cost of any charges associated with such a call.

4. That we have read this agreement and understand its terms. A copy or facsimile of this document shall have the same legal effect as the original.

_____ _____

Signature of Patient/ Authorized Representative: Date:

SAN TAN SMILES
1355 S. HIGLEY RD STE 114
GILBERT, AZ 85296
(480) 457-8818

If you are not the patient, please identify your Relationship to the patient
(Circle or mark relationship(s) from list below):

Spouse Parent Other (please specify): _____

_____

Signature of Witness and Title: