PATIENT INFORMATION

LAST NAME:______________________ FIRST NAME:______________________ SEX: M F

DATE OF BIRTH: ______________ AGE: ________ SOC. SEC #: ________ - ______ - __________

ADDRESS Street: ______________________________________ APT #: _________

CITY: ______________________ STATE: ____________ ZIPCODE: ________________

CELL PHONE #: ______________________ HOME PHONE #: ______________________

E-MAIL: ______________________ APPT REMINDERS: TEXT & / or E-MAIL ***(circle one or both)***

RESONSIBLE PARTY (if different from above): ______________________________

ADDRESS (responsible party): ______________________________

EMERGENCY CONTACT: PHONE # RELATIONSHIP:

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

DENTAL INSURANCE COVERAGE INFORMATION

INSURANCE COMPANY:	***Subscriber ID # / Member ID# :***
Subscriber Name:	***Subscriber Birth date:***

Please LIST current medications:

DO YOU PREMEDICATE FOR DENTAL VISITS? YES / NO Medication: ______________________

Please review and indicate YES or NO to indicate if you HAVE, or have HAD any of the following:

	Y	N		Y	N		Y	N
AIDS/HIV positive			Emphysema			Rapid weight gain/loss		
Anaphylaxis			Environmental Allergies			Radiation Treatment		
Anemia			Epilepsy			Respiratory Disease		
Arthritis, Rheumatism			Fainting/Dizziness			Rheumatic/Scarlet Fever		
Artificial Heart Valves			Food Allergies			Sensory Disorder		
Artificial Joint(s) (location):			Glaucoma			Shortness of Breath		
______________________			Headaches			Sinus Trouble		
Asthma			Heart Murmur			Skin Rash		
Back Problems			Heart Problems (describe):			Spina Bifida		
Blood Disease			______________________			Stroke		
Bleeding Disorder			Hepatitis Type A / B / C			Swelling of feet/ankles		
Cancer (type):			Herpes / Shingles			Thyroid Disease		
______________________			High Blood Pressure			Tobacco Habit		
Chemical Dependency			Jaundice			Tonsillitis		
Chemotherapy			Jaw Pain			Tuberculosis		
Circulatory Problems			Kidney Disease			Tumor/Growth on Head/Neck		
Cortisone Treatments			Liver Disease			Ulcer		
Cough (persistent)			Low Blood Pressure			Venereal Disease		
Cough (bloody)			Mitral Valve Prolapse			Use of Fosomax/Boniva/Actonel?		
Dental Implant			Nervous Problems			Use of Fen-Fen/Redux?		
Diabetes			Pacemaker			Other:		
WOMEN: Are you Pregnant?			Nursing?			Taking Birth Control?		

ALLERGIES

(check all that apply)

	Aspirin
	Codeine
	Local Anesthetics
	Penicillin
	Barbiturates
	Iodine
	Latex
	Sulfa
	Other: __________

How long has it been since your last dental visit?
Do you have any dental concerns or teeth that are bothering you?

AUTHORIZATION

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform my dentist.

I authorize my insurance company to pay the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. **PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED**

Your comfort is our prime concern. Do you like to be **INFORMED** every step of the way? Or do you like it **QUIET** during your dental visits? (circle one)

Patient/Guardian SIGNATURE: ______________________________ DATE: ____________

reviewed by: ________________

Jonathan Lovell, DMD Michelle Rock, DDS

Ph 480.615.8585 9963 E Baseline Rd, Ste 101 Mesa, AZ 85209 Fax 480.615.8686

Thank you for choosing our office for your dental needs. We are committed to providing the highest quality of dental care. In order to reduce potential miscommunications, we have adopted the following policies and request that you read and sign/initial prior to beginning treatment.

PATIENT INFORMATION: Personal information, including your insurance carrier, address, telephone numbers and other pertinent contact information **MUST BE UPDATED ON AN ANNUAL BASIS**. It is your responsibility to know your insurance benefits, terms and exclusions. We work with many insurance companies and hundreds of plans, and although we are happy to assist you in understanding your coverage, it is not possible that we know each policy in detail. If you take issue with the denial of a claim, it is your responsibility to contact your insurance company directly.

______________ initial

MINORS: A parent or legal guardian must accompany a minor to his/her visit at our office, so we can obtain permission to treat the minor patient. A minor may be treated on subsequent visits without a parent or guardian if we have written permission from the parent or legal guardian. The adult accompanying the minor patient is responsible for patient co-pay at the time of service.

______________ initial

INSURANCE DEDUCTILBES & CO-PAYS: Our insurance contracts require us to collect deductibles and co-pays **AT THE TIME OF SERVICE**. If you have insurance with a plan that we do not participate with, or you have no dental insurance coverage, full payment for services rendered is due at the time of service. We do accept Visa, Master Card, American Express, Discover, Care Credit, cash and personal check as payment methods. A $35 fee will be charged for all returned checks.

______________ initial

APPOINTMENT CONFIRMATIONS AND CANCELLATIONS: It is your responsibility to remember your appointment. Reminder calls are made as a courtesy only. Do not rely on them. Appointments must be cancelled 24 hours prior to the scheduled appointment time. **A $50 fee may be charged for all appointments missed without 24 hour notice.**
NOTE: WE USE TEXT/EMAIL FOR CONFIRMATION. IF YOU OPT OUT OF THIS SERVICE, YOU WILL BE RESPONSIBLE FOR REMEMBERING YOUR APPOINTMENTS.

______________ initial

LOCAL ANESTHETIC: You understand that local anesthetic is used during certain dental procedures. Although very rare, risks and complications associated with this may include; bruising, pain at the injection site, needle breakage, and paresthesia.

______________ initial

RELEASE AND ASSIGNMENT: You hereby authorize Eastridge Family Dentistry to release necessary information to your insurance company for the purpose of claim filing and payment of your dental services. You understand that you are financially responsible for all charges NOT paid by the insurance company. You are responsible to pay any deductibles, co-pays, and non-covered services under the terms of your insurance contract. You understand that once your insurance company has paid their portion of your bill, it will be your responsibility to remit payment within 15 days after receipt of a statement.

______________ initial

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT: You are aware that Eastridge Family Dentistry's HIPAA policy is posted in the office and a copy is available to you upon request.

______________ initial

I have read, understand, and agree to the above Financial and Privacy policies.

X____ Date:____________________