

Patient Information		
Date _____		
Patient's Name-Last _____	First _____	Middle _____
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	Age _____	Sex: M F Birthdate _____
Address-Street _____	City _____	State _____ Zip _____
Home Phone _____	Cell Phone _____	Social Security # _____ - _____ - _____
If Patient is a minor, give both parents' or guardians' names _____		
Who may we thank for referring you to our office? _____		

Responsible Party Information		
Name-Last _____	First _____	Middle _____
Mailing Address-Street _____	City _____	State _____ Zip _____
How long at this address? _____	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 Address _____	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 Address _____	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 if notice is less than 48 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. 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 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?

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

- | | | |
|---|---|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or Popping Jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food catches between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> 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 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 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:

San Tan Smiles **Office Policies**

- As a condition of your treatment by this office, you agree to pay for treatment at time of service. We will file your insurance claim; however your co-payment is due at the time of service. You understand that any balance remaining after your insurance payment is **your** responsibility.
- We accept Visa, MasterCard, checks and cash as payment. Payment plans are only accepted through Care Credit. (Information is available at the front desk)
- I understand that the fee estimate given on treatment plans can only be extended for a period of 60 days from the date of patient examination. Fees determined by insurance companies are subject to change without notice.
- Your appointment time is reserved just for you. If you are unable to keep your appointment, please notify the office with at least 24 business hours in advance. Please note \$50.00 could be assessed if advance notification has not been given.
- I understand that if my account goes past 90 days, it could be turned over to a collection agency or justice of the courts. I agree to pay all finance charges, collection costs, attorney fees and any other costs that may be incurred to enforce collection of any amount outstanding.
- I grant permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.
- I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian

Date

Relationship to patient