Queen Creek Cosmetic & Family Dentistry

We are pleased to welcome you to our practice!
Please take a few minutes to fill out this form completely.

Patient Information

Name: _____

Address: _____

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

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

Email Address: _____

Social Security # (REQUIRED) _____

Single □ Married □ Widowed □ *Date of Birth:* _____

Patient Employed By: _____ *Occupation:* _____

Business Address: _____

Notify in case of Emergency: _____ *Relationship:* _____

Emergency Contact Phone #: _____

Who May We Thank for Referring You: _____

Are you interested in?

□ *Whiter Teeth* □ *Straighter Teeth* □ *White Fillings*
□ *Replacement of Mercury Fillings* □ *Healthier Gums*
Are you happy with your smile? □ *Yes* □ *No* *If No, why?* _____

Insurance Information

Person Responsible for Account: _____

Relation to Patient: _____ *DOB:* _____ *Soc Sec #:* _____

Address (if different than patient): _____

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

Insurance Company: _____ *Phone #:* _____

Group #: _____ *Subscriber ID:* _____

Name of other dependants under this plan: _____

Medical History

Physicians Name: _____ *Phone #:* _____

Date of Last Visit: _____ *Currently Under Care?* _____ *If Yes, Why?* ____

Have you had any serious illness or operations: _____ *If Yes, describe:* _____

List of Medications you are taking: _____

Women: Are you pregnant? _____ *Nursing?* _____ *Birth Control Pills?* __

Check off all that apply:

□ *AIDS/HIV*	□ *Anemia*	□ *Arthritis*	□ *Artificial Joints*
□ *Artificial Heart Valves*		□ *Asthma*	□ *Blood Disorder*
□ *Cancer*	□ *Chemical/Alcohol Dependency*		□ *Chemotherapy*
□ *Cough up Blood*	□ *Diabetes*	□ *Epilepsy*	□*Fainting*
□ *Glaucoma*	□ *Headaches*	□ *Heart Murmurs*	□ *Heart Problems*
□ *Hemophilia/Abnormal Bleeding*		□*Herpes*	□ *Hepatitis*
□ *Liver Disease*	□ *Mitral Valve Prolapse*		□ *Nervous Problems*
□ *Pacemaker*	□ *Psychiatric care*	□ *Radiation Therapy*	□ *Rheumatics*
□ *Shortness of breath*	□ *Skin Rash*	□ *Stroke*	□ *Surgical Implant*
□ *Swelling Feet*	□ *Tobacco Habit*	□ *Tonsillitis*	□ *Tuberculosis*

Please check any Allergies:

□ *Latex Rubber* □ *Material Allergies* □ *Penicillin/Antibiotics*
□ *Local Anesthetics (i.e. Novocain)* □ *Barbiturates* □ *Iodine*
□ *Sulfa Drugs* □ *Aspirin* □ *Sedatives*
□ *Other* _____

Dental History

Date of last Dental appointment: _____ *Date of last X-rays:* _____
Date of Last Cleaning: _____ *History of Gum Therapy:* □ *Yes* □ *No*

Check if you have a problem with any of the following:

□ *Bad Breath*
□ *Food Collection between teeth*
□ *Loose Teeth/Broken Fillings*
□ *Sensitivity to Cold*
□ *Sensitivity to Hot*
□ *Sensitivity to Sweets*
□ *Sensitivity to Biting*
□ *Sores/Growth in Mouth*

Are there any other dental concerns that you'd like to address?

_____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis/records of any treatment/examination rendered to me during the period of such dental care to third party payers/health practitioners. I authorize and request my insurance to pay directly to the dentist/dental group 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 dependants. I am aware of the missed appointment/cancellation fee. If I fail to speak to the office staff at least two business days prior to appointment.

Signature: _____ *Date:* _____

Doctor's Signature: _____ *Date:* _____
Doctor's Comments:

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Missed Appointment Policy

Missed appointments and appointments cancelled without a 2 business day notice are subject to a cancellation fee of $50 per half hour of the scheduled appointment time. Any appointments scheduled for 90 or more minutes are subject to a minimum cancellation fee equal to 50% of the procedure(s) fee.

Signature: _____ Date: _____
Print Name: _____

Queen Creek Cosmetic & Family Dentistry
NOTICE OF PRIVACY PRACTICES

Purpose: This Notice of Privacy Practices presents the information of the HIPPA Privacy Rules.

We must provide this Notice to each patient no later than the date of our first service delivery to the patient, after April 14th, 2003. We must also have the Notice available at eh office for patients to request to take with them. Whenever we revise the Notice, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised notice in our office as discussed above.

We must make a good faith effort to obtain a written acknowledgement of receipt of this Notice from each individual with whom we have a direct treatment relationship and to whom we provide this Notice, except in emergency situations. If we do not obtain the acknowledgement, we must document our efforts and the reason we did not obtain the acknowledgement. The last page of the Notice is a written acknowledgement that each patient must sign. We should keep the acknowledgement in the patient's medical record.

I, _____, acknowledge that I have received a Notice of Privacy Practice from the above name practice.

Signature: _____ Date: _____

Our Privacy Practice in its entirety is available upon request.