AZ Denture Center

19082 N. Rh Johnson Blvd | Suite G • Sun City West, AZ 85375--4501 (623)214-7898

Chart#: MA0063
FOR OFFICE USE ONLY

Patient Name: _____* _____* _____ _____
Last First MI Preferred Name

Title: _____ **Gender:*** ◯ Male ◯ Female **Family Status:*** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date:* _____ **SS#:** _____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____* _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____* _____
Address 1 Address 2

_____* _____* _____*
City State Zip Code

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Whom may we thank for referring you to our practice?

Emergency Contact? Please enter Name and phone Number?

Who is your primary care physician? What phone number?
Specialist if any?

Health History Form

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

*Pre-Med - Amox *	◯ Yes ◯ No	*Pre-Med - Clind *	◯ Yes ◯ No
*Pre-Med - Other *	◯ Yes ◯ No	Allergies *	◯ Yes ◯ No
Allergy - Aspirin *	◯ Yes ◯ No	Allergy - Codeine *	◯ Yes ◯ No
Allergy - Erythro *	◯ Yes ◯ No	Allergy - Hay Fever *	◯ Yes ◯ No
Allergy - Latex *	◯ Yes ◯ No	Allergy - Other *	◯ Yes ◯ No
Allergy - Penicillin *	◯ Yes ◯ No	Allergy - Sulfa *	◯ Yes ◯ No
Allergy- EPINEPHRINE *	◯ Yes ◯ No	Anemia *	◯ Yes ◯ No
Arthritis *	◯ Yes ◯ No	Artificial Joints *	◯ Yes ◯ No
Asthma *	◯ Yes ◯ No	Blood Disease *	◯ Yes ◯ No
Blood Transfusion *	◯ Yes ◯ No	Breathing problems *	◯ Yes ◯ No
Bruise Easily *	◯ Yes ◯ No	Cancer *	◯ Yes ◯ No
Chest pain *	◯ Yes ◯ No	Cold Sores *	◯ Yes ◯ No
Cortisone Medicine *	◯ Yes ◯ No	Diabetes *	◯ Yes ◯ No
Dizziness *	◯ Yes ◯ No	Easily Winded *	◯ Yes ◯ No
Epilepsy *	◯ Yes ◯ No	Excessive Bleeding *	◯ Yes ◯ No
Fainting *	◯ Yes ◯ No	Glaucoma *	◯ Yes ◯ No
HIV *	◯ Yes ◯ No	Hay Fever *	◯ Yes ◯ No
Head Injuries *	◯ Yes ◯ No	Heart Attack *	◯ Yes ◯ No
Heart Disease *	◯ Yes ◯ No	Heart Murmur *	◯ Yes ◯ No
Heart Pacemaker *	◯ Yes ◯ No	Heart Trouble *	◯ Yes ◯ No
Hepatitis *	◯ Yes ◯ No	High Blood Pressure *	◯ Yes ◯ No
High Cholesterol *	◯ Yes ◯ No	Hives or Rash *	◯ Yes ◯ No
Irregular heartbeat *	◯ Yes ◯ No	Jaundice *	◯ Yes ◯ No
Kidney Disease *	◯ Yes ◯ No	Kidney Problems *	◯ Yes ◯ No
Liver Disease *	◯ Yes ◯ No	Mental Disorders *	◯ Yes ◯ No
Nervous Disorders *	◯ Yes ◯ No	Other *	◯ Yes ◯ No
Pacemaker *	◯ Yes ◯ No	Pregnancy *	◯ Yes ◯ No
Radiation Treatment *	◯ Yes ◯ No	Respiratory Problems *	◯ Yes ◯ No
Rheumatic Fever *	◯ Yes ◯ No	Rheumatism *	◯ Yes ◯ No
Shingles *	◯ Yes ◯ No	Sinus Problems *	◯ Yes ◯ No
Stomach Problems *	◯ Yes ◯ No	Stroke *	◯ Yes ◯ No
Thyroid Disease *	◯ Yes ◯ No	Tuberculosis *	◯ Yes ◯ No
Tumors *	◯ Yes ◯ No	Ulcers *	◯ Yes ◯ No
Venereal Disease *	◯ Yes ◯ No		

☐ Ever been hospitalized (illness or injury)
☐ Taking medication for weight control (ie fen-phen)
☐ Subject to frequent headaches
☐ Do you smoke or vape? If so, how much a day_____
☐ FEMALE: Pregnant
☐ Presently being treated for any other illnesses
☐ Taking dietary supplements
☐ Previous smoker?
☐ FEMALE: Taking birth control pills

Blood thinners (Coumadin, Plavix, Asiprin, Vitamin E, Ginko Biloba, Aggrenox, Xarelto, Eliquis, Fish Oil)? * ◯ Yes ◯ No

Any natural product, herbal supplement or homeopathic remedy? * ◯ Yes ◯ No

Do you have unhealed/recurrent injuries or inflamed areas, growths or sore spots in or around your mouth? * ◯ Yes ◯ No

Are you taking Fosomax or any bone maintenance Drug? ◯ Yes ◯ No

If any condition or alert selected above needs further clarification, please explain below:

List all medications, supplements, and/or vitamins taken within the last two years:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

Do you take antibiotic premedication for your dental visits? If yes, please explain.

Have you, or a family member, had any unusual or serious reactions to general anesthesia or IV sedation? * ◯ Yes ◯ No

If so, describe where

Have you had a heart valve replacement or vascular graft? * ◯ Yes ◯ No

If so, desribe where:

Have you ever had general anesthesia or IV sedation? * ◯ Yes ◯ No

Most recent physical exam and purpose: *

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

☐ **By checking this box, I acknowledge that the above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.**

Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist name and how long you have been a patient there:

_____

_____

Date of most recent dental exam: _____ **Date of most recent dental x-rays:** _____

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern?

_____

_____

Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) _____

Personal History, Check all that apply:

☐ Had an unfavorable dental experience ☐ Had complications from past dental treatment ☐ Had trouble getting numb

☐ Had any reactions to local anesthetic ☐ Had/have braces, orthodontic treatment ☐ Had your bite adjusted

☐ Had any teeth removed

Bite and Jaw Joint problem: ◯ Yes ◯ No

Gum and Bone, Check all that apply:

☐ Gums bleed when brushing or flossing

☐ Noticed an unpleasant taste or odor in your mouth

☐ History of periodontal disease in your family

☐ Experienced gum recession

☐ Had any teeth become loose on their own (without injury), or have difficulty eating an apple

☐ Experienced a burning sensation in your mouth

If any of the checked boxes need further explanation, please describe:

_____

_____

_____

_____

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ **By checking this box, I understand the above information and agree with its contents. This will serve as my electronic signature for the Administration Form.**

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

☐ **By checking this box, I understand the above information and agree with its contents. This will serve as my electronic signature for the HIPAA Disclosure Form.**

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

☐ **I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.**

I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

Response Date: _____