Chandler Dental Arts

Patient Information

Patient Name:____

Address____ Apt. #:__________

City:____________ State: ____________ Zip Code: ____________

Birthdate:____/____/____ Gender: ☐F ☐M Age:_____ Patient SS#: _____-_____-_____

Home Phone: ____________________ Cell: ____________________

Work Phone: _________________ Ext:______ Best Time to Reach You: ____________

I prefer to be called: ☐Mr. ☐Mrs. ☐Miss ☐Other ☐Singe ☐Married ☐Widowed ☐Separated ☐Divorced

Occupation:_________________________ Employer:__________________________

Spouse's Name:_______________________ Spouse's Occupation:____________________

Responsible Party:

Name of Responsible Party:__________________________ Relationship:________________

Address____ Apt. #:__________

City:____________ State: ____________ Zip Code: ____________

Birthdate:____/____/____ Age:_____ SS#: _____-_____-_____

Employer:_______________________________ Work Phone:____________ Ext._____

In Case of Emergency, Contact:(Specify someone who does not live in your household.)

Name:_____________________________________ Relationship:________________

Home Phone:__________________________ Work:__________________________

Who may we thank for referring you?____

Dental Insurance

Who is responsible for this account:____

Birthdate:____/____/____ SS#: _____-_____-_____ Relationship to Patient:____________

Insurance Co:_____________________________ Group#:__________________________

Is Patient covered by additional Insurance? ☐Yes ☐No

Assignment and Release

I certify that I (or my dependent) have insurance coverage as indicated and assign directly to this office all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____ ________________

Responsible Party Signature Date

Patient Medical History

Physician________________________Office Phone________________ _ ..e of last exam ________

Please circle yes or no on each category. If you are unsure put a question mark.

1. Are you under Medical treatment now?.......... Yes No
2. Have you ever been hospitalized for any surgical operation or serious illness within the last five years? If yes please explain...... Yes No

____

3. Are you taking any medications- including non-prescription medication?........................ Yes No

   List all medication ________________________

____

4. Have you ever taken Phen-Fen/Redux?........ Yes No
5. Do you use tobacco?.................................... Yes No
6. Do you use controlled substances?.............. Yes No
7. Are you wearing contact lenses?.................. Yes No

9. Are you allergic to or had a reaction to the following?

Local Anesthetic (e.g. Novocain)........	Yes	No
Penicillin or other Antibiotics............	Yes	No
Sulfa Drugs................................	Yes	No
Barbiturates................................	Yes	No
Sedatives....................................	Yes	No
Iodine...	Yes	No
Aspirin..	Yes	No
Any Metals (e.g. nickel, mercury, ect.)	Yes	No
Latex Rubber (gloves).....................	Yes	No
Other (please list)...........................	Yes	No

____

10. Women Only:

a.) Are you pregnant or think you might be?........ Yes No
b.) Are you nursing?.. Yes No
c.) Are you taking oral contraceptives?................. Yes No

8. Do you have or have you had any of the following?

High Blood Pressure.........	Yes	No	Heart Disease..............	Yes	No	Chest Pain.....................	Yes	No
Heart Attack................	Yes	No	Cardiac Pacemaker.........	Yes	No	Easily Winded.................	Yes	No
Rheumatic Fever.............	Yes	No	Heart Murmur...............	Yes	No	Stroke...........................	Yes	No
Swollen Ankles..............	Yes	No	Angina........................	Yes	No	Hay Fever/Allergies..........	Yes	No
Fainting/Seizures............	Yes	No	Emphysema.................	Yes	No	Turberculosis..................	Yes	No
Low Blood Pressure.........	Yes	No	Arthritis......................	Yes	No	Glaucoma......................	Yes	No
Epilepsy/Convulsion.........	Yes	No	Thyroid Problems...........	Yes	No	Recent Weight Loss..........	Yes	No
Leukemia......................	Yes	No	Frequently Tired............	Yes	No	Liver Disease..................	Yes	No
Diabetes.......................	Yes	No	Hepatitis/Jaundice..........	Yes	No	Heart Trouble..................	Yes	No
Kidney Disease...............	Yes	No	Anemia........................	Yes	No	Respiratory Problems.........	Yes	No
AIDS or HIV Infection......	Yes	No	Mitral Valve Prolapse......	Yes	No	Stomach Troubles/Ulcers.....	Yes	No
Asthma........................	Yes	No	Cancer........................	Yes	No	Radiation Therapy............	Yes	No
Joint Replacement or Implant...	Yes	No	Sexually Transmitted Disease...	Yes	No	Other ____________		

Patient Dental History:

Name of Previous Dentist and Location________________________ Date of Last Exam: ____________

1. Do your gums bleed while brushing or flossing?.............Yes No
2. Are your teeth sensitive to hot or cold liquids/foods?......Yes No
3. Are your teeth sensitive to sweet or sour liquids/foods?...Yes No
4. Do you feel pain to any of your teeth?............................Yes No
5. Do you have any sores or lumps in or around your mouth?..Yes No
6. Have you had any head neck or jaw injuries?.................Yes No
7. Have you ever experienced any of the following problems in your jaw?
   - Clicking..Yes No
   - Pain (joint, ear, side of face)?..Yes No
   - Difficulty in opening or closing your jaw?......................Yes No
   - Difficulty in chewing?..Yes No
8. Do you have frequent headaches?....................Yes No
9. Do you clench or grind your teeth?..................Yes No
10. Do you bite your lips or cheeks frequently?...Yes No
11. Have you ever had any difficult extractions in the past?...Yes No
12. Have you ever had any prolonged bleeding following extractions?....................................Yes No
13. Have you had any orthodontic treatment?.......Yes No
14. Do you wear dentures or partials?..................Yes No
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?.....Yes No
16. Do you like your smile?...................................Yes No

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge, and have accurately answered the questions. I understand 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 payers and/or health practitioners. I authorize and request my insurance plan to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental plan 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.

Signature of Patient, Parent or Guardian: ________________________ Date: ____________

Doctors Comments: ________________________________

Doctor's Signature: ________________________ Date: ____________

Chandler Dental Arts

Financial Policy

At Chandler Dental Arts, our goal is to provide quality dentistry at a fair price and a healthy and happy environment for all of our patients. We provide our services with honesty and integrity and expect the same from those we serve.

A $25.00 charge will be made for all missed appointment that are not cancelled or rescheduled at least 24 hours prior to the scheduled appointment time.

As a service to our patients we submit dental claims to their insurance for payments. We ask that each patient pay their deductible and or estimated portion at the time of service unless alternate arrangements have been made. If for any reason, the insurance company does not pay estimated amount, it becomes the patient share. Please monitor insurance payments. Our payment options include Cash, Visa, and Mastercard.

Our goal is to provide the best treatment possible for our patients and we charge the usual and customary rates in our area. To do so the patient is responsible for paying the balance in full regardless of the insurance company's determination of usual and customary rates.

I have read, understand , and agree to the above Financial Policy regarding my payments and insurance obligations. I will notify Chandler Dental Arts if any changes on insurance, address, or phone numbers occur.

Patient's Name:______________________________ DOB:______________

Patient's Signature:____________________________ Date:______________

NOTICE OF PRIVACY PRACTICE

Patient Acknowledgment of Receipt

Chandler Dental Arts

The Healthcare Notice of Privacy Practices recognizes that patients have the Rights to Privacy concerning their personal health information. We make every effort to protect and preserve patient records in a manner that secures this information.

By signing this acknowledgment:

You are only confirming that you understand the Privacy Practices of this office.

Print your name:____

Sign your Name:____

Today's Date:____

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