

Patient Information

Muliess					_ Apt. #:	
City:State:						
Birthdate:/						
Home Phone:						
Work Phone:	Ext:	I	Best Time to Re	each You: _		
prefer to be called: \(\partial Mr. \) \(\partial Mrs. \)						
Occupation:						
Spouse's Name:						
Responsible Party:						
Name of Responsible Party:			Rel	ationship:		
Address						
City:State:						
Birthdate://						
Employer:						Ext
In Case of Emergency, Contact: Name:	(Specify someone w	vho does not	t live in your ho	ousehold.) ationship:		,
In Case of Emergency, Contact: Name:	(Specify someone w	vho does not	t live in your ho	ousehold.) ationship:		,
In Case of Emergency, Contact: Name: Home Phone:	(Specify someone w	vho does not	t live in your ho	ousehold.) ationship:		,
In Case of Emergency, Contact: Name: Home Phone: Who may we thank for referring the Dental Insurance Who is responsible for this accounts.	g you?	vho does not	t live in your ho	ousehold.) ationship:		
In Case of Emergency, Contact: Name: Home Phone: Who may we thank for referrin Dental Insurance Who is responsible for this account.	g you?nt:	vho does not	t live in your ho	ationship:	Patient:	
In Case of Emergency, Contact: Name: Home Phone: Who may we thank for referring Dental Insurance	g you?nt:	vho does not	t live in your ho	ationship:	Patient:	

Responsible Party Signature

Date

Patient Medical History

surgical operation or serious illness within he last five years? If yes please explain. Yes No Penicillin or other Antibiotics. Yes No Sulfa Drugs. Yes No Sulfa Drugs. Yes No Sulfa Drugs. Yes No Sulfa Drugs. Yes No Sedatives. Yes No Sedatives. Yes No Sedatives. Yes No Sedatives. Yes No Any Metals (e.g. nickel, mercury, et.) Yes No Any Metals (e.g. nickel, mercury, et.) Yes No Any Metals (e.g. nickel, mercury, et.) Yes No Other (please list). Yes	surgical operation or serious illness within the list five years? If yes please explain. Yes No Pencillin or other Ambibotics. Yes No Sulfa Drugs. Yes No Sulfa Drugs. Yes No Sodairves. Yes No Sodairves. Yes No Sodairves. Yes No Sodairves. Yes No Aspirin. Yes No Any Metals (e.g. mickel, mercury, ect.) Yes No Cher (please list). Yes No Other (please list). Yes No No (please list). Yes No (p						
he last five years? If yes please explain Yes No Barbitrates Yes No Sedatives Yes No Are you taking any medications- including No prescription medication? Yes No Any Metals (c.g., nickel, mercury, ect.) Yes No Oby ou use tobacco? Do you use tobacco? Yes No Any Metals (c.g., nickel, mercury, ect.) Yes No	the last five years? If yes please explain. Yes No Surfa Drugs. Yes No Barbiturates. Yes No Schadives. Yes No Schadives. Yes No Schadives. Yes No Schadives. Yes No Holmon-prescription medications- including non-prescription medications. Yes No Any Metals (e.g. mickel, mercury, ect.) Yes No Any Metals (e.g. mickel, mercury, ect.) Yes No Other (please list). Yes No Display of the following Please No Display of the following Ple	**			nesthetic		
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Aspirin. Yes No Any Metals (e.g. nickel, mercury, ect.) Yes No Latex Rubber (gloves). Yes No Other (please list). Yes No Latex Rubber (gloves). Yes No Other (please list). Yes No Do you use tobacco? Yes No a.) Are your pregnant or think you might be? Yes No Do you use controlled substances? Yes No b.) Are your teath sensitive to hot or cold liquids/foods? Yes No C.) Are you taking oral contraceptives? Yes No Do you have or have you had any of the following? Yes No Cardiac Pacemaker. Yes No Chest Pain. Yes No Heart Attack. Yes No Heart Murmur. Yes No Stroke. Yes No Remains (Persure. Yes No Angina. Yes No Hay Fever/Allergies. Yes No Fainting/Seizures. Yes No Angina. Yes No Glaucoma. Yes No Fainting/Seizures. Yes No Thyroid Problems. Yes No Glaucoma. Yes No Epilepsy/Convulsion. Yes No Hepatitis/Jaundice. Yes No Recent Weight Loss. Yes No Anthrits. Yes No Heart Trouble. Yes No Hollabetes. Yes No Hepatitis/Jaundice. Yes No Respiratory Problems. Yes No Anthrits. Yes No Respiratory Problems. Ye	Aspinn. — Yes No Aspinn. — Yes No Cheer Equity (e.g.) Yes No Other (please list). — Yes No Other						
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Have you ever taken Phen-Fen/Redux?	Have you ever taken Phen-Fen/Redux?. Yes No 10. Women Only: Do you use tobacco? Yes No b, JA re you pregnant or think you might be? Yes No Do you use controlled substances? Yes No b, JA re you rearing contact lenses?. Yes No b, JA re you naving?. Yes No Poyou have or have you had any of the following? High Blood Pressure. Yes No Heart Disease. Yes No Chest Pain. Yes No Reart Attack. Yes No Cardiac Pacemaker. Yes No Easily Winded. Yes Nowline Analides. Yes No Heart Attack. Yes No Heart Murmur. Yes No Hay Fever/Allergies. Yes No Heart Providers. Yes No Hay Fever/Allergies. Yes No Heart Trouble. Yes No Hollson. Yes No Heart Trouble. Yes No Hollson. Yes No Hollson. Yes No Heart Trouble. Yes No Hollson. Yes No Hollson. Yes No Hollson. Yes No Heart Trouble. Yes No Hollson. Yes N			Latex F	Rubber (gl	oves)Yes No	
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Do you use tobacco?	Do you use tobacco?	Yes N		10. Wo	men Only	r.	
Do you use controlled substances?	Do you use controlled substances?	Yes N		a.) Are	you pregi	nant or think you might be? Yes	No
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Swollen Ankles	Swollen Ankles. Yes No Emphysema Yes No Turberculosis. Yes No Epilepsy/Convulsion. Yes No Turberculosis. Yes No Epilepsy/Convulsion. Yes No Thyroid Problems. Yes No Glaucoma. Yes No Epilepsy/Convulsion. Yes No Thyroid Problems. Yes No Recent Weight Loss. Yes No Epilepsy/Convulsion. Yes No Frequently Tired. Yes No Heart Trouble. Yes No Diabetes. Yes No Heaptitis/Jaundice. Yes No Heart Trouble. Yes No Kidney Disease. Yes No Anemia. Yes No Heart Trouble. Yes No Kidney Disease. Yes No Anemia. Yes No Mitral Valve Prolapse. Yes No Radiation Therapy. Yes No Asthma. Yes No Cancer. Yes No Radiation Therapy. 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. 1. Do your gums bleed while brushing or flossing? Yes No 9, Do you clench or grind your teeth? Yes No Are your teeth sensitive to but or cold liquids/foods? Yes No 9. Do you clench or grind your teeth? Yes No 10. Do you bite your lips or checks frequently? Yes No 10. Do you bite your lips or checks frequently? Yes No 11. Have you ever had any prolonged bleeding fool woy or wouth? 1. Have you ever experienced any of the following problems in your jaw? 2. Have you had any head neck or jaw injuries? Yes No 12. Have you ever had any prolonged bleeding problems in your jaw? 2. Have you ever experienced any of the following problems in your jaw? 2. Have you ever experienced any of the following Press No 15. Have you ever teceived oral bygiene instructions of 15. Have you ever teceived oral bygiene instructions Profifculty in opening or closing your jaw? Yes No 15. Have you ever teceived oral bygiene instructions Profifculty in opening or closing your jaw? Yes No 16. Do you like your smile? Yes No 15. Have you ever the and gums? Yes No 15. Have you ever the and gums? Yes No 16. Do you like your smile? Yes No 16.						
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Diabetes	Diabetes	Frequent	v Tired	Yes			No
Kidney Disease	Kidney Disease						No
AIDS or HIV Infection	AdDS or HIV InfectionYes No Cancer				No	Respiratory ProblemsYes	
Asthma	Asthma	Mitral V	alve Prolapse	eYes	No	Stomach Troubles/UlcersYes	
Joint Replacement or ImplantYes No Sexually Transmitted DiseaseYes No Other atient Dental History: ame of Previous Dentist and Location Date of Last Exam: Do your gums bleed while brushing or flossing?Yes No Southward Previous Dentist and Location Do your gums bleed while brushing or flossing?Yes No Southward Previous Dentist and Location Do you gums bleed while brushing or flossing?Yes No Southward Previous Dentist and Location Are your teeth sensitive to hot or cold liquids/foods?Yes No Southward Previous Do you be pour teeth sensitive to sweet or sour liquids/foods?Yes No Southward Previous Do you be pour lips or cheeks frequently?Yes No Southward Previous	Patient Dental History: Name of Previous Dentist and Location						iNo
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Do your gums bleed while brushing or flossing?	1. Do your gums bleed while brushing or flossing?					Date of Last Exam:	
Are your teeth sensitive to hot or cold liquids/foods?Yes Are your teeth sensitive to sweet or sour liquids/foods?Yes Are your teeth sensitive to sweet or sour liquids/foods?Yes Do you feel pain to any of your teeth?Yes Do you have any sores or lumps in or around your mouth?Yes Have you had any head neck or jaw injuries?Yes Have you ever experienced any of the following problems in your jaw? ClickingYes No 9. Do you clench or grind your teeth?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 ClickingYes No 14. Do you wear dentures or partials?Yes No 15. Have you ever received oral hygiene instructions	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? ClickingYes No Difficulty in opening or closing your jaw? Yes No Difficulty in chewing?Yes No Difficulty in chewingYe		No	g Do	you have	frequent headaches? Yes	No
Are your teeth sensitive to sweet or sour liquids/foods?Yes Do you feel pain to any of your teeth?	2. Ale your teeth sensitive to sweet or sour 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?	ing?Y	es No	9. Do	you nave	h or grind your teeth?Yes	No
Do you feel pain to any of your teeth? Do you feel pain to any of your teeth? Do you have any sores or lumps in or around your mouth? Have you had any head neck or jaw injuries? Have you ever experienced any of the following problems in your jaw? Clicking 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	4. Do you feel pain to any of your teeth?	15/10005 / 1	s No	10. Do	you clene	your lips or cheeks frequently?Yes	No
Do you have any sores or lumps in or around your mouth?	in the past?	3. Are your teeth sensitive to sweet of sour riquids/100ds:165 100 100 100 100 100 100 100				ver had any difficult extractions	
your mouth?	your mouth? 6. Have you had any head neck or jaw injuries? 7. Have you ever experienced any of the following problems in your jaw? Clicking	ad	,,,	in	the past?	Yes	No
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problems in your jaw? Clicking	Clicking	wing		13. H	ave you h	ad any orthodonuc treatment? Yes	INO
Clicking	Clicking Yes No 14. Do you wear dentities of partials instructions Pain (joint, ear, side of face)? Yes No 15. Have you ever received oral hygiene instructions Difficulty in opening or closing your jaw? Yes No regarding the care of your teeth and gums? Yes No Difficulty in chewing? Yes No 16. Do you like your smile? Yes No 16. Do you like your smile? Yes No No Information to the best of my knowledge, and have accurately answer questions. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to releginformation including the diagnosis and the records of any treatment or examination rendered to me or my child during the passed dential care to third party payers and/or health practitioners. I authorize and request my insurance plan to pay directly dentist or dental group insurance benefits otherwise payable to me. I understand that my dental plan carrier may pay less actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.		27	14 D	o vou me	or dentures or partials? Yes	No
THE INC. LEGISLAND VIOLENCE OF THE PROPERTY OF	Difficulty in opening or closing your jaw?	Y	es No	14. D	ave von e	ver received oral hygiene instructions	
Pain (bill, ear, side of labeling very low? Ves No regarding the care of your teeth and gums?Yes No	Difficulty in chewing?	Y	s No	re	garding th	ne care of your teeth and gums?Yes	No
THITICITY III ODCINIES OF CLOSING JOAN JAMES AND	Authorization and Release I certify that I have read and understand the above information to the best of my knowledge, and have accurately answer questions. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to releginformation including the diagnosis and the records of any treatment or examination rendered to me or my child during the pusuch dental care to third party payers and/or health practitioners. I authorize and request my insurance plan to pay directly dentist or dental group insurance benefits otherwise payable to me. I understand that my dental plan carrier may pay less actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.	Y.	s No	16. D	o you like	your smile?Yes	No
Difficulty in opening or closing your jaw?Yes No regarding the care of your teeth and gums?Yes	I certify that I have read and understand the above information to the best of my knowledge, and have accurately and questions. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to reinformation including the diagnosis and the records of any treatment or examination rendered to me or my child during the such dental care to third party payers and/or health practitioners. I authorize and request my insurance plan to pay direct dentist or dental group insurance benefits otherwise payable to me. I understand that my dental plan carrier may pay less actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.	wing Y Y	es No es No	13. H 14. D 15. H	ave you h o you wea ave you e	ad any orthodontic treatment?Yes ar dentures or partials?Yes ver received oral hygiene instructions ne care of your teeth and gums?Yes	
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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:	

Chandler Dental Arts•501 W. Ray Rd. #10 Chandler, AZ. 85225•(480)963-0077

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:

Chandler Dental Arts•501 W. Ray Rd. Suite #10 Chandler, AZ. 85525•(480)963-0077