



**PATIENT INFORMATION**

Patient Name \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
 Married Y/N \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_ Drivers Lic#: \_\_\_\_\_  
 Spouse/Significant Other name: \_\_\_\_\_ Phone \_\_\_\_\_  
 Children/Siblings residing with you \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Ext \_\_\_\_\_  
 Cell Phone # \_\_\_\_\_ E-mail Address \_\_\_\_\_  
 Preferred contact method (circle) Home Phone Cell Phone Work Phone Email Text Message  
 Employer/School \_\_\_\_\_ Occupation/Department \_\_\_\_\_  
 Full Time \_\_\_\_\_ Part Time \_\_\_\_\_  
 Employer Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Emergency Contact (not living with you) \_\_\_\_\_ Phone \_\_\_\_\_  
 Date of Last Dental Visit \_\_\_\_\_ Date of Last Dental X-rays \_\_\_\_\_

**BILLING INFORMATION**

(Circle) Self Spouse Parent

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Ext \_\_\_\_\_  
 Cell Phone # \_\_\_\_\_ E-mail Address \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_  
 Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
 Employer Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**PRIMARY DENTAL INSURANCE**

Subscriber Name \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_  
 Subscribers Date of Birth \_\_\_\_\_  
 Subscribers SS/ID# \_\_\_\_\_  
 Address (if different from patient) \_\_\_\_\_  
 \_\_\_\_\_  
 Subscribers Employer \_\_\_\_\_  
 Insurance Company \_\_\_\_\_  
 Group # \_\_\_\_\_

**SECONDARY DENTAL INSURANCE**

Subscriber Name \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_  
 Subscribers Date of Birth \_\_\_\_\_  
 Subscribers SS/ID# \_\_\_\_\_  
 Address (if different from patient) \_\_\_\_\_  
 \_\_\_\_\_  
 Subscribers Employer \_\_\_\_\_  
 Insurance Company \_\_\_\_\_  
 Group # \_\_\_\_\_

**DENTAL HISTORY**

Name \_\_\_\_\_ Date \_\_\_\_\_

Please Check All that Apply:

- |  |  |   |   |
|--|--|---|---|
| <input type="radio"/> Toothache                    | <input type="radio"/> Bad previous dental work                         | <input type="radio"/> Dry or strained eyes        | <input type="radio"/> Unusual habits with teeth |
| <input type="radio"/> Broken filling or tooth      | <input type="radio"/> Gums bleed                                       | <input type="radio"/> Shoulder, neck or headaches | <input type="radio"/> Wore braces               |
| <input type="radio"/> Clench or grind teeth        | <input type="radio"/> Gums tender                                      | <input type="radio"/> Clench or grind teeth       | <input type="radio"/> Previous gum treatment    |
| <input type="radio"/> Food catches                 | <input type="radio"/> Growths, Sores                                   | <input type="radio"/> Jaw joint pain              | <input type="radio"/> Previous bite treatment   |
| <input type="radio"/> Loose teeth                  | <input type="radio"/> Cold sores, fever blisters                       | <input type="radio"/> Clicking or popping of jaw  | Sensitivity to:                                 |
| <input type="radio"/> Floss breaks easily or hurts | <input type="radio"/> Cracked chapped lips                             | <input type="radio"/> Unable to open mouth wide   | <input type="radio"/> Cold                      |
| <input type="radio"/> Bite or teeth have shifted   | <input type="radio"/> Bad taste in mouth                               | <input type="radio"/> Jaw tires easily            | <input type="radio"/> Hot                       |
| <input type="radio"/> Often bite cheek             | <input type="radio"/> Sinus problems                                   | <input type="radio"/> Hold things between teeth   | <input type="radio"/> Sweets                    |
| <input type="radio"/> Frequent dry mouth           | <input type="radio"/> Mouth breathe - Difficult breathing through nose | <input type="radio"/> (pipe, pencil, nails, pins) | <input type="radio"/> Chewing                   |
| <input type="radio"/> Concerned about breath       |  | <input type="radio"/> Bite fingernails            |   |

Would you like whiter teeth? \_\_\_\_\_ Is there anything that bothers you (even just a little) about the appearance of your teeth or smile? \_\_\_\_\_

Please rate 1-10 how anxious you are about dental treatment (1 = totally relaxed) \_\_\_\_\_

Have you ever had a bad experience at the dentist? (Treatment? Staff? Billing?) \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

**MEDICAL HISTORY**

Physicians Name: \_\_\_\_\_ Are you allergic to penicillin, aspirin, local anesthetics, latex, City: \_\_\_\_\_ Phone: \_\_\_\_\_ sulfa, codeine, other? \_\_\_\_\_

Have you ever been hospitalized for any reason? Please Describe: Do you Smoke? How much/day? \_\_\_\_\_

Pregnant? Due date: \_\_\_\_\_ Are you nursing?

Are you taking any medications or drugs (including nutritional supplements?) Please list: (Continue on back of form if needed) \_\_\_\_\_

Are you seeing a physician now or planning to see one for any reason? Please explain: \_\_\_\_\_

Please check all that apply:

- |   |   |   |   |
|---|---|---|---|
| <input type="radio"/> Allergies                     | <input type="radio"/> Fainting            | <input type="radio"/> Jaundice              | <input type="radio"/> Rheumatic Fever     |
| <input type="radio"/> Anemia                        | <input type="radio"/> Glaucoma            | <input type="radio"/> Kidney Disease        | <input type="radio"/> Rheumatism          |
| <input type="radio"/> Arthritis                     | <input type="radio"/> Head Injuries       | <input type="radio"/> Liver Disease         | <input type="radio"/> Shortness of Breath |
| <input type="radio"/> Artificial Heart Valve/Joints | <input type="radio"/> Heart Attack        | <input type="radio"/> Low Blood Pressure    | <input type="radio"/> Sinus Problems      |
| <input type="radio"/> Asthma                        | <input type="radio"/> Heart Disease       | <input type="radio"/> Mental Disorders      | <input type="radio"/> Stomach Problems    |
| <input type="radio"/> Blood Disease                 | <input type="radio"/> Heart Murmur        | <input type="radio"/> Mitral Valve Prolapse | <input type="radio"/> Stroke              |
| <input type="radio"/> Cancer                        | <input type="radio"/> Heart Problems      | <input type="radio"/> Nervous Disorders     | <input type="radio"/> Thyroid             |
| <input type="radio"/> Chest Pains                   | <input type="radio"/> Heart Stents        | <input type="radio"/> Other                 | <input type="radio"/> Tobacco Use         |
| <input type="radio"/> Diabetes                      | <input type="radio"/> Hepatitis           | <input type="radio"/> Pacemaker             | <input type="radio"/> Tuberculosis        |
| <input type="radio"/> Dizziness                     | <input type="radio"/> High Blood Pressure | <input type="radio"/> Pregnancy             | <input type="radio"/> Tumor               |
| <input type="radio"/> Epilepsy                      | <input type="radio"/> HIV/AIDS            | <input type="radio"/> Radiation Treatment   | <input type="radio"/> Ulcers              |
| <input type="radio"/> Excessive Bleeding            | <input type="radio"/> Hypothyroid         | <input type="radio"/> Respiratory Problems  | <input type="radio"/> Venereal Disease    |

Any other illnesses not checked above: \_\_\_\_\_

Any other illnesses not checked above: \_\_\_\_\_ {I will inform this office of any changes in my health status. I certify that the above information is completed and accurate to the best of my knowledge.}

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

### APPOINTMENT GUIDELINES

We believe in the value of clear communication, as well as mutual understanding and respect prior to treatment rendered. It is our desire to provide high-quality dental care and individual attention for you in a timely manner. Your appointment time has been reserved especially for you and we make every effort to remind patients of their appointment as a courtesy. Therefore, if you break an appointment without 2 business days notice, we do not have sufficient amount of time to rebook another patient in need of treatment. With this in mind, a **\$50.00 fee may be subject to the second missed appointment or cancellation less than 2 business days from your scheduled time.** This fee must be paid in full prior to any further appointment(s) scheduled.

### FINANCIAL & DENTAL INSURANCE GUIDELINES

Any monies due directly from the patient for services rendered are due **in full at the time of service** unless other arrangements are made in advance. We accept all major debit/credit cards, cash and checks. There will be a **\$35.00 service charge** on all returned checks. Understanding Dental Insurance is complicated for both the insured and the Doctor. When a patient gives us an insurance card we call the insurance company to get your benefit information-usually in the form of a fax which contains basic benefit coverage. When we put together a treatment plan for needed dental work diagnosed by the Doctor, we are basing the patient portion off of the information provided by your insurance company. As a courtesy to our patients we will collect your estimated co-pay in full at the time of service and bill the insurance directly for their estimated portion of treatment. If the insurance has not made their payment after 30 days of the claim being sent, we will supply the patient or guarantor with everything needed to contact their insurance in order to follow-up on their dental claim.

It is the mission of Dr. Lee and every staff member that from the moment you step through our front door, you have the best dental experience possible. In order to achieve this, your help is required. We are asking for everyone to help out and make sure their treatment is paid for in a timely fashion.

**ANY BALANCE DUE AFTER 60 DAYS IS PAYABLE IN FULL FROM THE PATIENT WITHIN 10 DAYS OF NOTICE. Patient is responsible for any collections fees, attorney fees, and court costs that could/will be accrued for any outstanding balances.**

### AUTHORIZATION FOR SIGNATURE ON FILE

I \_\_\_\_\_ hereby authorize payment of dental benefits otherwise payable to me, directly to the office listed above. I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf. This "signature on file" will be valid from the date signed. A photocopy of this document may act as an original.

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Signature

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Date

**EVERY SMILE MESA  
NOTICE OF PRIVACY PRACTICES & HIPAA ACKNOWLEDGMENT FORM**

Effective Date: January 1, 2026 Arizona

**THIS NOTICE DESCRIBES HOW MEDICAL AND DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**OUR RESPONSIBILITIES**

Every Smile Mesa is required by law to maintain the privacy and security of your protected health information (PHI), provide you with this Notice of Privacy Practices, and follow the duties and privacy practices described in this notice. We will notify you promptly if a breach occurs that may have compromised the privacy or security of your information.

**HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION**

We may use and disclose your protected health information for the following purposes:

We may use your information to provide, coordinate, or manage your dental and medical care and share it with other healthcare providers involved in your treatment.

**Payment**

We may use and disclose your information to bill and receive payment from insurance companies or other third parties.

**Healthcare Operations**

We may use your information to run our practice, improve patient care, train staff, and conduct quality assurance activities.

**Appointment Reminders and Communications**

We may contact you for appointment reminders, treatment follow-up, billing matters, or office communications.

**Other Uses and Disclosures Permitted or Required by Law**

We may disclose your information when required by federal or Arizona law, for public health and safety purposes, abuse or neglect reporting, law enforcement, judicial proceedings, or other legally permitted situations.

**SUBSTANCE USE DISORDER (SUD) INFORMATION**

If we create or receive records related to substance use disorder treatment that are protected under federal law (42 CFR Part 2), those records will receive additional protections. Such information will not be used or disclosed without your written consent except as specifically permitted by law. Federal law generally prohibits redisclosure of substance use disorder records without your explicit authorization or a valid court order.

**REDISCLASURE NOTICE**

Information disclosed by our office may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations.

## FUNDRAISING COMMUNICATIONS (IF APPLICABLE)

If our office engages in fundraising activities, you have the right to opt out of receiving fundraising communications at any time by notifying us in writing.

### YOUR RIGHTS

You have the right to:

- Inspect and obtain a copy of your health records
- Request corrections to your records
- Request confidential communications
- Request restrictions on certain uses or disclosures (we are not required to agree to all requests)
- Receive an accounting of certain disclosures
- Receive a paper or electronic copy of this notice
- File a complaint if you believe your privacy rights have been violated

Complaints may be filed with our office or with the U.S. Department of Health and Human Services. You will not be retaliated against for filing a complaint.

### COMMUNICATION AUTHORIZATION

Please indicate how we may contact you (check all that apply):

Phone call (may leave voicemail)

Text message

Email

Mail

Preferred contact number/email: \_\_\_\_\_

I understand that electronic communications may not always be encrypted and may carry some privacy risk.

### AUTHORIZED INDIVIDUALS

I authorize the following individuals to receive information regarding my dental care and account:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I do not authorize anyone to receive my information.

### CHANGES TO THIS NOTICE

Every Smile Mesa reserves the right to change this notice and make the new notice effective for all protected health information we maintain. Updated notices will be available in our office and upon request.

### ACKNOWLEDGMENT OF RECEIPT

By signing below, you acknowledge that you have been offered a copy of this Notice of Privacy Practices and understand your rights regarding your protected health information. You understand that you may revoke authorizations in writing at any time.

Patient/Guardian Name: \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_



3960 E. University Dr  
Mesa, AZ 85205  
480-830-8686

[www.https://everysmilemesadentist.com](https://www.everysmilemesadentist.com)

## **Patient Photo Release Form**

I \_\_\_\_\_, hereby authorize Every Smile Mesa or any of their assignees to take photographs, slides, and videos of my teeth, jaws, and face. I understand that the photographs, slides, and videos will be used as a record of my care and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, Facebook or Instagram posts, etc.).

I further understand that if the photographs, slides, and videos are used in any publication or as a part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing.

If declining this consent, leave blank.

Please initial one option:

\_\_\_\_\_ I do not mind if my photographs are used in any of the above stated situations.

\_\_\_\_\_ I only agree to have my teeth shown without any identifying features.

Signed \_\_\_\_\_ Date \_\_\_\_\_