FAMILY DENTISTRY EVERY smile + ORTHODONTICS

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 #_____

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DENTAL HISTORY

Name_____Date_____

Please Check All that Apply:

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

Sensitivity to:

- ❍ Cold
- ❍ Hot
- ❍ Sweets
- ❍ Chewing

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 H IS TO R Y

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:

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

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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.

_____ _____

Signature Date

How Your Health Information May Be Used

To Provide Treatment

We will use your HEALTH INFORMATION within our officer to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist and business office staff. In addition, we may share your health information with physicians, referring dentist, clinical and dental laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with similar commitment to the security of your health information.

In Patient Reminders

We will remind you of any scheduled appointments or when it is time for you to make an appointment. We may also contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgement, when we believe we are specifically require to authorized by law or with the patient's agreement.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your ho9me hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency where you are unable to tell us what you want, we will use our very best judgement when sharing your health information only when it will be important to those participating in providing your care.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State, or Local law require us, we will not disclose your health information other that with your written authorization. You may revoke that authorization in writing at any time.

PATIENT ACKNOWLEDGMENT

List Patients Names:

_____
_____
_____
_____

Thank you for taking the time to review how we carefully use your health information. If you have any questions, we want to hear from you. If not, we appreciate your acknowledging your understanding of our policy by signing below.

Signature_____
Relationship to patient_____
Date_____

Every Smile Mesa

3960 E. University Dr
Mesa, AZ 85205
480-830-8686
www.https: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_____