PATIENT REGISTRATION

Patient Information

Date			
Patient's NameLast	First	Middle	eferred Name
Address		Birth Date	
Home Phone #	Cell #	Work #	
E-Mail Address			
Gender: □ Male □ Female	Marital Status: 🗆 M	Iarried □ Single □ Divorced	□ Separated □ Widowed
Who may we thank for referring	you to our office?		
	Responsible Pa	rty Information (if someone	other than patient)
NameLast	First	Middle	
Home Phone #	Cell #	Work #	
Relationship to Patient			
We ask that you please notify us at leas	at 48 hours in advance if needing to chang	e or cancel any appointments - or a \$5	0.00 charge will be assessed to your account.
	_	- 0	•
		Information	
Name of Primary Insured		Relationship to Patient	□Self □Spouse □Child □Other
Insured SS# or Alternate ID#		Insured Birth Date _	
Name of Insurance Co.		Employer	
City, State, Zip			
Phone #		Phone #	
Name of Secondary Insured		Relationship to Patient	□Self □Spouse □Child □Other
Insured Social Security		Insured Birth Date	
Name of Insurance Co.			
		Address	
		City, State, Zip	
,		Phone #	

HEALTH HISTORY QUESTIONNAIRE

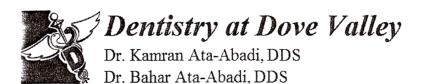
It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

NAME (Last, First, MI.)					Birtl	hdate	
	PERS	ONAL HE	ALTH HIS	TORY			
Do you smoke or use Tobacco in any other form? Yes No Do you drink excessively Yes No	Have you ever taken Fosamax, any other bisphosphonate? ARE YOU ALLERGIC TO OR HAY TO ANY OF THE FOLLOWING! Aspirin Local Anest Penicillin Codeine Are you aware of being allerging or substances? if yes, please I	VE REACTED MEDICATION hetic E	ADVERSELY NS? (CIRCLE) Erythromycin Latex ter medication	such as	Fen-Phen/R For Women: Are you preg Are you nurs	nant?	S NO
Last COMPLETE Dental Exam, Are you having PROBLEMS no WHAT? Are you currently in PAIN? Do you wear DENTURES? (Pa Are you APPREHENSIVE abou Do your gums BLEED, SORE, S Are your teeth SENSITIVE To Are your teeth loose? Are you WHAPPY with the A Are you aware of GRINDING Have you worn BRACES on yo Do you have DISCOLORED tee Would you like your smile to Do you REGULARLY use DENT *MEDICAL HIST Do you have CURRENT HEAL! Are you under PHYSICIAN'S C For WHAT? Have you had surgery? If so, Please Specify Do you have numbness or pa Do you have nor plession or Do you have chronic horsene Do you have lump or thicken Do you snore or have you be Is there a history of heart dis Do you have a family history Medications Taken:	rtials or Full) It dental treatment? SWOLLEN or TENDER or IRRITATED hot, cold, sweets, pressure? (circle) PPEARANCE of your teeth? Or CLENCHING your teeth? Our teeth (ORTHODONTICS) eth that bother you? LOOK BETTER or DIFFERENT? TAL FLOSS? TORY* TH PROBLEMS? CARE now? In in the FACE/NECK/MOUTH In lips or mouth for more than 2 wks ess ing in the cheek en told you snore? ease in your immediate fami of diabetes?		AIDS/HIV P Anaphylaxi Anemia Arthritis (Ri Artificial he Artificial jo Asthma Atopic (aller Back Probl Blood Dise Cancer Chemical of Chemothe Circulatory Cortisone of Cough (per Cough up l Diabetes Epilepsy Fainting Food Aller, Glaucoma Heart Mur Heart problem Is there ar I should kn	YES OR NO CITLY HAVE: OS. Someumatism) eart valves ints rgy prone) eems ase dependency raphy y problems treatments rsistent) blood gies rmur blems (pls descr a (abnormal blee now about	YES NO	Hepatitis High Blood Pressure High Cholesterol Jaw pain Kidney disease or malfuncti Liver Disease Mitral valve prolapse Nervous problems Pacemaker/heart surgery Psychiatric care Rapidweight gain/loss Radiation Treatment Respiratory disease Rheumatic/scarlet fever Shingles Shortness of breath Skin rash Sleep Apnea Spina Bifida Stroke Surgical Implant Swelling of feet/ankles Thyroid disease/malfunction Tonsillitis Tubercolosis Ulcer Colitis Venereal disease tal info that you feel	YES NO
	t/guardian)						
Doctor's Signature				Date			

Additional Questions

1.	Are you happy with the appearance of your teeth? Yes No
2.	How do you rate the health of your teeth and gums? A. Good B. Fair C. Poor
3.	Would you like to have whiter teeth? Yes No
4.	Are you interested to know more about Invisalign , the invisible braces to straighten teeth? Yes No
5.	If any of the following conditions apply to you, you may be a candidate for oral sedation (Sleep Dentistry): a. high fear of dentistry b. traumatic past dental experiences c. difficulty getting numb/extremely sensitive teeth d. limited time to complete extensive dental treatment
Sleep Dentistry is a safe, simple and effective oral conscious sedation technique that may be used in conjunction with nitrous oxide gas (it is NOT general anesthesia and there are no IV tubes or needles involved). You will be given two or three small pills prior to your appointment and you'll be sedated just enough to be unaware of the treatment. You will be very relaxed and comfortable and will wake up within a few hours with little or no memory of your appointment. One of our team members will be with you during your entire visit and your vital signs will be constantly monitored. If you are in relative good general health there are only two requirements for sleep dentistry: 1. No food or drink (except water) for six hours prior to treatment time. 2. You will need a responsible adult to accompany (drive) you to and from the office. If you are interested in sleep dentistry or have further questions, please check here: Yes	
	Signature Date,

Dentistry at Dove Valley (480)595-5688



4705 E Carefree Hwy, Suite 126 Cave Creek, AZ 85331 (480) 595-5688 fax (480) 595-9233 dentistryatdovevalley@yahoo.com

Financial Policy

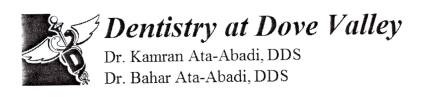
Welcome to our practice!

We know that providing complete comprehensive dental services includes discussing all treatment and financial information. Before treatment is performed, we will discuss treatment and financial options. This will allow you to fully understand your dental treatment, what to anticipate in fees and allow you time to make the necessary financial arrangements.

In order to better serve you, we want you to be aware of our office policies:

- Payment is due at the time services are rendered, unless other arrangements have been made. For your convenience we accept cash, checks/money orders, and major credit cards. CareCredit financing may also be available to you.
- 2. Insurance is not a guarantee of payment; it often does not cover all the costs involved in treatment. Any deductible or estimated co-pay amount will be due at the time of treatment; in addition, you will be responsible for any amount your plan does not pay.
- 3. Appointments are reserved exclusively for you. We reserve the right to charge and collect \$20.00 for any broken appointments. Broken appointments are considered those that are missed (no-show) and cancelled with less than 24-hour advance notice.
- 4. For the treatment of minors (under the age of 18), written consent from a parent or legal guardian is required for treatment.

Thank you again for choosing our office as your dental health provider.	
I HAVE READ AND UNDERSTAND THIS POLICY AND AGREE TO ITS TERMS.	
Patient or Guardian Signature	Date



4705 E Carefree Hwy, Suite 126 Cave Creek, AZ 85331 (480) 595-5688 fax (480) 595-9233 dentistryatdovevalley@yahoo.com

Insurance Policy

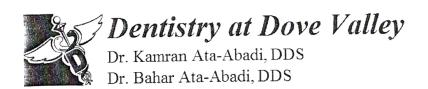
Due to the frequent changes in insurance plans and policies, we want to avoid as much misinformation as possible. Insurance benefits are determined by your employer, not your dentist; your insurance coverage and benefits are your responsibility. *Insurance is not a guarantee of payment, and it often does not cover all the costs involved in treatment.*

You will be expected to pay for services rendered if this office is unable to verify your insurance information before treatment. Any deductible or estimated co-payment amount will be due at the time of treatment. In addition, you will be responsible for any amount your insurance plan does not pay, due (but not limited) to:

- A. Cost of treatment goes over your insurance company's yearly maximum benefit.
- B. Your insurance company denies treatment.
- C. You are not eligible for insurance.
- D. Your insurance benefits are less than what was estimated.
- E. You prevent or delay payment by not complying with requests for insurance forms and signatures.
- F. You do not complete treatment, and it results in non-payment by your insurance company.
- G. Lab costs are incurred due to your failure to appear at your appointments.

We make every effort to ensure fees and co-pays are as accurate as possible at the time of your appointment; however, due to the volume and constant changes in insurance plans, we cannot assume responsibility for any discrepancies that may arise.

I HAVE READ AND UNDERSTAND THIS POLICY AND AGREE TO ITS TERMS.	
Patient or Guardian Signature	Date



4705 E Carefree Hwy, Suite 126 Cave Creek, AZ 85331 (480) 595-5688 fax (480) 595-9233 dentistryatdovevalley@yahoo.com

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received and read and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that the organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the **Notice of Private Practices.**

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment and payment of health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions

Patient Name	
Relationship to Patient	
Signature	
Date	