



Tempe Dental Care

5801 S. McClintock Drive
Tempe, AZ 85283

Thank you for visiting Tempe Dental Care. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information

Name _____
LAST FIRST MIDDLE INITIAL PREFERRED NAME

Address _____
STREET

CITY STATE ZIP

Employer _____ Driver License _____

Birth Date _____ Married Single Other

Height _____ Weight _____ Male Female

Phone: Home (_____) _____ Social Security # _____

Work (_____) _____

Cell (_____) _____ Email: _____

Emergency Contact: Name _____ Phone (_____) _____

How did you hear about us? Yellow Pages Google Yahoo DexKnows Walk in/Drive by Insurance
 Referral _____ Other _____

Insurance

Primary Dental Carrier

Subscriber Name _____ Subscriber ID # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Secondary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

The information on this page is correct to the best of my knowledge. (Sign & Date)

Signature _____ Date _____

If Patient is under 18

Responsible Party _____ Relation to Patient _____

Address _____
STREET CITY STATE ZIP

Telephone (_____) _____

Other Information

Physician's Name _____ Physician's Phone _____

Have you had a serious illness or operation? Y () N ()

If yes, please describe _____

Are you currently under physician care? Y () N ()

If yes, please describe _____

Medical History and Information

Conditions

- Abnormal Bleeding
- Alcohol Abuse
- Allergies
- Anemia
- Angina Pectoris
- Arthritis
- Artificial Heart Valve**
- Asthma
- Blood Transfusion
- Cancer
- Chemotherapy
- Colitis
- Congenital Heart Defect
- Diabetes
- Difficulty Breathing
- Drug Abuse
- Emphysema
- Epilepsy
- Facial Surgery
- Fainting Spells
- Fever Blisters
- Frequent Headaches
- Glaucoma
- HIV+ Aids
- Heart Attack**

- Joint Replacement**
- Heart Murmur**
- Heart Surgery
- Hemophilia
- Hepatitis A
- Hepatitis B
- Hepatitis C
- High Blood Pressure
- Kidney Problems
- Liver Disease
- Low Blood Pressure
- Mitral Valve Prolapse**
- Pace Maker
- Psychiatric Problems
- Radiation Therapy
- Rheumatic Fever**
- Seizures
- Sexually Transmitted Disease
- Shingles
- Sickle Cell Disease
- Sinus Problems
- Stroke
- Thyroid Problems
- Tuberculosis
- Ulcers

Allergies

- Aspirin
- Codeine
- Dental Anesthetics
- Erythromycin
- Latex
- Metals
- Penicillin
- Sulfa
- Tetracycline

Other _____

Y N

- Do you Smoke
or use Tobacco?

If Female

Y N

- Are you taking Birth
Control Pills?

- Are you pregnant?
If yes, # of weeks _____

- Are you nursing?

Please list any medications you are currently taking:

Have you EVER taken any bisphosphonates? (e.g. Fosomax, Actonel) Y () N ()

Treatment Authorization Form

The information on this page is correct to the best of my knowledge. I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility.

PATIENTS SIGNATURE

DATE

If patient is a child or requires a guardian:

PARENT/GUARDIAN SIGNATURE

DATE

Acknowledgement of Receipt of Notice of Privacy Practices

We must provide this Notice to each patient no later than the date of our first service delivery to the patient. We must also have the Notice available at the office for patients to request to take with them. Whenever we revise the Notice, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice.

We must make a good faith effort to obtain a written acknowledgement of receipt of this Notice from each individual with whom we have a direct treatment relationship and to whom we provide this Notice, except in emergency situations. If we do not obtain the acknowledgement, we must document our efforts and the reason we did not obtain the acknowledgement. The last page of the Notice is a written acknowledgement that each patient should sign. We should keep the acknowledgement in the patient's dental record.

I, _____, acknowledge that I have received a Notice of Privacy Practice from Tempe Dental Care.

Signature _____ Date _____

Missed Appointment Policy

Due to the high number of patients requiring dental care, waiting times for appointments can be long. Because of this, we enforce a missed appointment policy to ensure that other patients receive care in a timely manner.

Missed appointments and appointments cancelled without 24-hour notice are subject to a cancellation fee of \$25 per hour of the scheduled appointment time.

Signature _____ Date _____

Print Name _____

Insurance Policy

IMPORTANT:

- ❖ We are working for you and not the insurance company.
- ❖ We have no control over how well they pay or how they treat you.
- ❖ There are thousands of combinations of insurance plans and coverages depending on what your employer purchased for you.
- ❖ **WE DO NOT BASE OUR CLINICAL EXAM OR YOUR TREATMENT PLAN ON WHAT YOUR INSURANCE COVERS OR DOESN'T COVER.**

Our policy is as follows:

1. If any payment from an insurance company becomes 30 days past due, then you will be immediately billed for the entire balance.
2. We will file your pre-treatment estimates, at your request, as a service to you. Please be aware that some insurance companies may not honor a pre-treatment estimate or may alter it. In all cases it will delay important dental care.
3. Insurance companies have yearly and sometimes lifetime maximums. It is your responsibility to keep track of this yourself. Sometimes we don't even receive this type of information from the insurance company. You will be responsible for any additional charges incurred. We apologize that we have to have such an involved office policy concerning insurance, however, from past experience we have learned that sometimes there is a big difference in what coverage you think or have been told you have and what the companies actually pay for you. The bottom line of our policy is that we will help you all we can, but any difference in what the insurance company pays and the charges for the services we provide for you is due from you.

Patient

Signature _____ Date _____



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RECEIVE APPOINTMENT REMINDERS VIA EMAIL AND TEXT!!

PLEASE CHECK A SOURCE IN WHICH YOU WOULD LIKE TO RECEIVE APPOINTMENT REMINDERS

- Email
- Text Message
- Both Email and Text Message

Email Address: _____
(if applicable)

Cell Phone: _____
(if applicable)

We use this information to provide you with excellent treatment. We may disclose Patient Health Information (PHI) to third parties that perform services for Tempe Dental Care in the administration of your benefits in accordance with HIPAA. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate that performs services for Tempe Dental Care in the administration of your benefits. Our affiliates do not sell, share or rent our users' personally identifiable information unless required by law, do not send and e-mail or other communications without user permission, and do not send spam.

Please sign below that you agree to allow us to use this information in providing your services.

Signature: _____

Print: _____

Date: _____