602.404.7266
602.494.2389 fax

4611 E. Shea Blvd. Ste. 250
Phoenix, AZ 85028

LifeSmilesDentalCare.com

We would like to get to know you better!

Date__________________

Name____SS#_________________________ ☐ Male ☐ Female

Address____City_____________State__________Zip_____________ _

Home Phone____________________________Work Phone_________________________Cell phone_________________________

E-mail Address____Date of Birth_______________________

Occupation____Employer____

Parent or Spouse's Name____Their Phone # _________________________________ _

Who may we thank for referring you? ____

Person to Contact in case of emergency______________________________________Phone_________________________________

Person responsible for dental investment ____

For dependents 18 years and older that are covered under parents insurance we will need their student status for insurance processing.

Student Status*:* Full Time Total Semester Hr's_____________________Part Time Total Semester Hr's______________________

For Insurance Purposes:

Name of policy holder_________________________Date of Birth___________________Relationship to Patient: ______________

SS#_____________________Member I.D.____________________________Employer ___________________________________

Insurance Company ____

Ins. Company Phone #____Group Number_____________________________

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HIPPA Compliance Statement

Your health information may be used in our office to conduct scheduling and coordination of care between the doctor, dental assistant, hygienist, business office staff, and other dental specialists that are involved in your care. 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. Your health information may be reviewed during the routine process of certification, licensing, credentialing activities or auditing for quality assurance.

Communication with our patients in an important part of our philosophy. We prefer to communicate with you directly but we may incorporate the use of phone messages, postcards, and letters. We will make every effort to respect your privacy and honor your request for confidentiality. If you have special needs in regards to privacy issues, please put them in writing for the office so that we may address your concerns.

Financial Information:

I have read and truthfully answered the above questions to the best of my knowledge. I authorize the doctor and/or his staff to release all information necessary to secure payment of my benefits from my insurance company.

I understand that fees may vary at the time of service due to the extent of treatment. Fees are estimates only and are not a guarantee of payment by my insurance company. I understand that the payment of this account is my responsibility, regardless of the amount my insurance company reimburses before or after payment in made.

●●

Patient Signature:____Date: _______________

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Patient Name: ______________________________

Medical History *Please circle (Y) for "yes" or (N) for "no" for any of the following which may apply to you now or in the past:*

Y N Heart attack or Heart Trouble
Y N Congenital Heart Disease
Y N Chest pain with exercise (angina)
Y N High Blood Pressure
Y N Heart Valve disorder
Y N Pacemaker
Y N Implants or Artificial Joint When?
Y N Anemia or blood disorder
Y N Excessive bleeding
Y N Diabetes Recent A_1C? ______
Y N Stroke When? ____________
Y N Thyroid disease
Y N Asthma
Y N HPV

Y N Ulcers, Reflux, or Heartburn
Y N Digestive disorders
Y N Kidney problems
Y N Fainting or Blackouts
Y N Headaches or Migraines
Y N Epilepsy or Seizures
Y N Tumors, Cancer, radiation treatment
Y N Tuberculosis, lung problems
Y N Hepatitis A B C D
Y N AIDS or HIV infections
Y N Psychiatric Disorders
Y N Use tobacco? How much? ________
Y N Drug/Alcohol dependency
Y N Sleep Apnea

Are you currently under a physician's care? Y N
If yes, please explain ______________________________
Have you had any serious illness, operations or been hospitalized in the past 5 years?
If yes, please explain ______________________________
Has your physician recommended that you take antibiotic prior to dental treatment? Y N
Have you ever had an allergic reaction to an anesthetic or drug such as penicillin, a sedative, aspirin, latex, or metals? If yes, please explain ______________________________
Is there anything else you would like us to know about your health? ______________________________
What prescription or over the counter drugs, medications, vitamins, or herbs are you taking at this time?

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Dental History

Y N Are you experiencing any dental discomfort?
Y N Is your mouth frequently dry?
Y N Does your jaw become sore with chewing?

Y N Sensitivity to: hot/cold/sweets/biting pressure?
Y N Do you grind your teeth?

How often do you brush your teeth?____________ How often do you floss your teeth? ______________

Y N Are you interested in improving the appearance of your smile? If yes, what would you like to change (ex: color, shape, straightening, longer teeth, less gummy)? ______________________________

Y N Do you become nervous or anxious during dental visits?
Please rate your level of dental anxiety on a scale from 0-10 (0=none 10=extreme): ________________
Have you ever had any problems associated with previous dental treatment?________________________

Patient Signature: ______________________________ Date: ______________
Dentist/Hygienist Signature: ______________________________ Date: ______________