Legacy Smiles of Southern Arizona

FULL LEGAL NAME ______________________ **Nickname**: ______________

MAILING ADDRESS ____
(City) *(State)* *(Zip)*

PERMANENT ADDRESS ____
(City) *(State)* *(Zip)*

Birthdate:______________ **Age** ________ **Social Security #**______________________

MARITAL STATUS: ☐ **SINGLE** ☐ **MARRIED** ☐ **DIVORCED** ☐ **WIDOWED** **SEX:** o **MALE** o **FEMALE**

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE: ______________________________

PHONES: Work: ________________ Home: ______________ Fax: ______________

Cell: ________________ **Email**:______________________________

OCCUPATION:________________ **EMPLOYER** & Address:______________________

INSURED/ACCOUNT RESPONSIBILITY if someone other than yourself: NAME______________________

INSURED Address: ______________________________ Daytime Phone: ______________

Their Social Security #: ______________Birthdate: ________ ID#______________ GROUP #________

OCCUPATION: ______________ EMPLOYER & Address: ______________________________

INSURANCE Plan Name and Address: ______________________________________

****PRIMARY REASON FOR TODAY'S VISIT**:______________________________________

DATE OF LAST DENTAL VISIT______________________

Primary Care Physician:______________________________________
Name Phone Number

Are you being treated by a Specialist now? ☐ Yes ☐ No Who? ______________________

For What?______________________________________

Pharmacy ________________Location______________Phone____________

IF FEMALE: o **Yes** o **No** **Are you taking birth control pills?** | ☐ **Yes** ☐ **No** **Do you Smoke or use tobacco?**
o **Yes** o **No** **Are you pregnant? If Yes, # of weeks**__________ |
☐ **Yes** ☐ **No** **Are you nursing?** | **Height**__________**Weight**__________

HEALTH HISTORY (please check if you have or had any of the following:)

☐ Yes ☐ No Allergies
☐ Yes ☐ No Anemia
☐ Yes ☐ No Angina Pectoris
☐ Yes ☐ No Arthritis
☐ Yes ☐ No Artificial Heart Valve
☐ Yes ☐ No Asthma, Breathing Problems
☐ Yes ☐ No Bleeding Problems, Blood Thinners
☐ Yes ☐ No Cancer - Chemotherapy
☐ Yes ☐ No Colitis
☐ Yes ☐ No Deep Cleanings, Gum Surgery
☐ Yes ☐ No Dental Anesthetic Sensitivity
☐ Yes ☐ No Depression, Psychiatric Problems
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Drug Abuse
☐ Yes ☐ No Emphysema
☐ Yes ☐ No Epilepsy
☐ Yes ☐ No Fainting Spells
☐ Yes ☐ No Frequent Headaches
☐ Yes ☐ No Glaucoma
☐ Yes ☐ No Good Health?
☐ Yes ☐ No HIV+ AIDS, ARC
☐ Yes ☐ No Hay Fever

☐ Yes ☐ No Health Changed In Last Year?
☐ Yes ☐ No Heart Attack
☐ Yes ☐ No Heart Surgery
☐ Yes ☐ No Hemophilia
☐ Yes ☐ No Hepatitis A, B, or C
☐ Yes ☐ No Herpes, Cold Sores, Fever Blisters
☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No Joint Replacement
☐ Yes ☐ No Kidney Problems
☐ Yes ☐ No Liver Disease, Cirrhosis
☐ Yes ☐ No Low Blood Pressure
☐ Yes ☐ No Lung Disease, TB
☐ Yes ☐ No Medical Marijuana
☐ Yes ☐ No Organ Transplant
☐ Yes ☐ No Osteoporosis
☐ Yes ☐ No Pacemaker
☐ Yes ☐ No Pain In Jaw Joints
☐ Yes ☐ No Radiation Therapy
☐ Yes ☐ No Recreational Drugs
☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No Seizures
☐ Yes ☐ No Shingles
o Yes o No Sinus Problems

☐ **Yes** ☐ **No** **Sleep Apnea**
☐ Yes ☐ No Stroke
☐ Yes ☐ No Thyroid Problems
☐ Yes ☐ No Ulcers
☐ Yes ☐ No Venereal Disease

ALLERGIES

☐ Yes ☐ No Aspirin
☐ Yes ☐ No Codeine
☐ Yes ☐ No Dental Anesthetics
☐ Yes ☐ No Erythromycin
☐ Yes ☐ No Jewelry
☐ Yes ☐ No Latex
☐ Yes ☐ No Metals
☐ Yes ☐ No Penicillin
☐ Yes ☐ No Tetracycline
Other:

o **Yes** o **No** **Do you wear a CPAP?**
o **Yes** o **No** **Do you snore?**

List any and all **DRUGS/MEDICATIONS** you are taking:

List any and all SURGERIES and dates:

____

____

____

____

EMERGENCY CONTACT:

NAME:_______________________________________ RELATIONSHIP:_________________ PHONE: _______________________

The above information is true and correct.

PATIENT SIGNATURE: ____ ***DATE:***____________________

I give permission for any photos taken by Legacy Smiles of Southern Arizona to be used for educational and promotional purposes.

PATIENT SIGNATURE: ____ ***DATE:***_________________________

PRIVACY PRACTICES ACKNOWLEDGEMENT

Privacy Notice Amendment September 2013

I have had the opportunity to read the Patient Privacy Notice for this practice. I understand that I may ask for a copy to take with me at any time, and that an appointed person is available to answer any questions that I may have now, or in the future, regarding the use on my Personal Health Information.

____ ____________________
patient signature date

____ ____________________
practice witness date

I would be interested in learning more about:

Getting my mouth "ready for retirement" plan
A cosmetic evaluation of my teeth
Whitening
HPV ID Saliva test
Periodontal Disease Gene ID Saliva Test
"Teeth in a Day" permanent total tooth replacement

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Consent for Use or Disclosure of Information
Requested by Legacy Smiles of Southern Arizona

I hereby permit Legacy Smiles of Southern Arizona to use my health information, and/or to disclose my health information to any third party payer, or to any party involved in my health care.

I understand that there is a copy of the Notice of Privacy Practice available in the reception area for me to read. I acknowledge that I have read or received a copy of the Notice of Privacy Practices.

Legacy Smiles of Southern Arizona has my permission to contact me in the following manner:

Home#:___________________Cell#______________________Work#_____________________Preferred #____________________

( ) Okay to leave a message with detailed information ( ) Okay to leave message with appointment confirmation

( ) Leave a message with call back number only ( ) Do not call…(how do we contact you)____________________

Legacy Smiles has my permission to release information to the following persons:

Spouse (name):________________________________ Caregiver (name & phone #):_______________________________

Other (name, relation & phone#):____

____ ____
Signature of Patient or Personal Representative Date:

FINANCIAL CONSENT

As a condition of your treatment by this office, financial arrangements must be made in advance.

Your dental insurance is an insurance policy contract between yourself and your insurance company. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. If your insurance company denies benefits or does not issue payment, you are responsible for any balance due.

All co-payments are the patient's responsibility. Patient agrees to pay for all dental services not paid by insurance coverage. Any balance remaining after dental procedure or from insurance payment after 30 days will accrue 25% APR on that unpaid balance unless payment arrangements have been made. If it becomes necessary to take enforcement to collect any amount due, whether in a court proceeding or otherwise, patient shall be responsible for all collections fees, attorney's fees and court costs, as well as the value of time lost by the provider or employee's provider, in any efforts to collect such debt.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

____ ____
Signature of Patient or Personal Representative Date

Full payment is required before treatment should you decline to sign the Financial Consent *even* if you have insurance.