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?

o Yes o No Are you pregnant? If Yes, # of weeks_____

☐ Yes ☐ No Are you nursing?

☐ Yes ☐ No Do you Smoke or use tobacco?

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.