Dr. Daniel Gold 480.977.1440

5900 N. Granite Reef Rd. #100 Scottsdale, AZ 85250

PATIENT INFORMATION

Name _____
LAST FIRST MIDDLE INITIAL PREFERRED NAME

Address _____
STREET

_____
CITY STATE ZIP

Birth date _____ Height _____ Weight _____

Best contact phone number (_____)_____ Social Security # _____

How did you hear about our office? _____

I give Scottsdale Dental Center permission to leave detailed information concerning my dental health on my voicemail YES❑ NO❑ Are we able to contact you via text message YES❑NO ❑

PARENTS INFORMATION

FATHER

Name _____
LAST FIRST MIDDLE INITIAL PREFERRED NAME

Address _____
STREET

_____
CITY STATE ZIP

Birth date _____ E-Mail Address _____

Home Phone (_____)_____ Social Security # _____

Work Phone (_____)_____ Cell (_____)_____

MOTHER

Name _____
LAST FIRST MIDDLE INITIAL PREFERRED NAME

Address _____
STREET

_____
CITY STATE ZIP

Birth date _____ E-Mail Address _____

Home Phone (_____)_____ Social Security # _____

Work Phone (_____)_____ Cell (_____)_____

DENTAL INSURANCE INFORMATION

Primary Carrier

Subscriber Name _____ Relationship to Patient _____ Subscriber DOB _____

Subscriber SSN/ID _____ Subscriber Employer _____

Insurance Company Name_____

Insurance Company Address _____

Insurance Company Phone _____ Group Number _____

Secondary Carrier

Subscriber Name _____ Relationship to Patient _____ Subscriber DOB _____

Subscriber SSN/ID _____ Subscriber Employer _____

Insurance Company Name_____

Insurance Company Address _____

Insurance Company Phone _____ Group Number _____

Insurance Authorization Statement (Sign & Date)

I, the undersigned, certify that my dependent has insurance coverage and assign directly to Scottsdale Dental Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party (Printed name): _____

Responsible Party Signature: _____

Relationship: _____ Date: _____

MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name_____

Physician's Phone_____

Date of last visit _____

Your current physical health is ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain_____

Do you use tobacco in any form? ❑ Yes ❑ No

Have you had any metal rods, pins or implants placed? ❑ Yes ❑ No

Are you taking any medications? ❑ Yes ❑ No

Please list each one_____

Have you ever had any surgical procedures? ❑ Yes ❑ No

Please list each one_____

Yes	No	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

Yes	No	Conditions
❑	❑	Glaucoma
❑	❑	HIV+ AIDS
❑	❑	Heart Attack
❑	❑	Heart Murmur
❑	❑	Heart Surgery
❑	❑	Hemophilia
❑	❑	Hepatitis A
❑	❑	Hepatitis B
❑	❑	Hepatitis C
❑	❑	High Blood Pressure
❑	❑	Joint Replacement
❑	❑	Kidney Problems
❑	❑	Liver Disease
❑	❑	Low Blood Pressure
❑	❑	Mitral Valve Prolapse
❑	❑	Pace Maker
❑	❑	Psychiatric Problems
❑	❑	Radiation Therapy
❑	❑	Rheumatic Fever
❑	❑	Seizures
❑	❑	Sexually Transmitted Disease
❑	❑	Shingles

Yes	No	Conditions
❑	❑	Sickle Cell Disease
❑	❑	Sinus Problems
❑	❑	Stroke
❑	❑	Thyroid Problems
❑	❑	Tuberculosis
❑	❑	Ulcers

Yes	No	Allergies
❑	❑	Aspirin
❑	❑	Codeine
❑	❑	Dental Anesthetics
❑	❑	Erythromycin
❑	❑	Jewelry / Metals
❑	❑	Sulfa
❑	❑	Penicillin
❑	❑	Tetracycline
❑	❑	Latex
❑	❑	Ibuprofen

Yes	No	If Female, Please Answer
❑	❑	Are you taking Birth Control Pills?
❑	❑	Are you pregnant? If so, # of Weeks___
❑	❑	Are you nursing?

Nearest relative not living with you:

Name: _____ Relationship: _____

Address: _____ Phone: _____

Emergency contact: _____ Relationship: _____ Phone: _____

I understand that the information that I have given today is correct to the best of my knowledge.
I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____Date:_____

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Parent / Guardian's Signature: _____

Office Use Only: **Health History Reviewed by _____ Date _____**

DENTAL HISTORY

How may we help you today?_____

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Are you currently in pain? ❑ Yes ❑ No

Have you ever had gum treatment? ❑ Yes ❑ No

Do you now or have you had any pain/discomfort in your joint? (TMJ) ❑ Yes ❑ No

Are you under stress? ❑ Yes ❑ No

Do you like your smile? ❑ Yes ❑ No

Is there anything you would like to change about your smile? ❑ Yes ❑ No

Are you happy with the color of your teeth? ❑ Yes ❑ No

Do your gums bleed? ❑ Yes ❑ No

How many times a do you: floss/week _____ brush/day? _____

Are your teeth sensitive to heat, cold or anything else? ❑ Yes ❑ No

Have you ever had a serious/difficult problem with any previous dental work? ❑ Yes ❑ No

Have you ever had any unfavorable dental experiences? ❑ Yes ❑ No

When was your last dental cleaning?_____

When was your last dental visit? _____

Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit? _____

_____

Here at Scottsdale Dental Center we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Tooth Whitening	Veneers	Invisalign
Smile Makeover	Bonding	Sealants
Crown and Bridge	Dental Implants	Partials/Dentures
Night/Sport Guards	Electric Toothbrush	

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I, _____, have received a copy of this office's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy from time to time and that I may contact this organization at any time to obtain a copy of the Notice Of Privacy Practices.

Patient Name_____

Relationship to Patient_____

Signature_____

Date_____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy, but was unable to do so as documented below:

Date	Initials	Reason

FINANCIAL POLICIES

Thank you, for choosing our office for your dental needs. We are committed to your treatment being successful and are always available to answer your questions or assist you in any way we can. The follow is a statement of our financial policy, which we require you to read and sign prior to any treatment.

- **All patients** must complete all forms prior to being seen by the doctor
- All treatment estimates are valid for 90 days
- **Full payment** is due at the time of service. We accept Visa, Master Card, Care Credit and debit cards
- A $35 charge is incurred for returned checks
- Any balance left unpaid after 90 days will be turned over to small claims or collections and the patient will be dismissed from the practice
- Patient is responsible for any and all attorney fees, collection fees and finance charges should the account be turned to a collection agency

Regarding Insurance We accept assignment of insurance benefits. The balance is YOUR RESPONSIBILITY whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. Please be aware that the estimates that are given are just that. We do not guarantee insurance coverage or benefits. Please be aware that some or all of the services provided may not be a covered service under your insurance plan. **It is your responsibility to find out what is and is not covered.** You will be responsible for any balance not paid by your insurance company.

Minors The adult accompanying a minor to his/her appointment is responsible for payment at the time of service. Minors will not be treated if unaccompanied.

Missed Appointments Unless cancelled at least **48 hours in advance**, our policy is to charge for missed appointments at the rate of $35 per half hour. This will help us cover a portion of our costs to make up for the time **especially reserved for you**. Please help us serve you better by keeping your scheduled appointments! Excessive missed or cancelled appointments will result in dismissal from the practice.

Thank you for understanding our Office Policy. Please feel free to let us know if you have any questions or concerns.

I have read, understand and agree to the above financial policy.

Financially Responsible Party (Printed Name) _____

Financially Responsible Party's Signature _____

Date _____