PATIENT NAME _____ TODAY'S DATE _____

HOME ADDRESS _____ DATE OF BIRTH _____

_____ HOME PHONE _____

E-MAIL _____ CELL PHONE _____

EMPLOYER _____ BUSINESS PHONE _____

INSURANCE CO. _____ SS#/SIN _____

PATIENT NAME

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

	YES	NO
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use alcohol, cocaine or other drugs?	☐	☐
7. Are you wearing contact lenses?	☐	☐

8. Are you allergic to or have you had any reactions to the following?

YES	NO		YES	NO		YES	NO	
☐	☐	Local anesthetics (eg. novocaine)	☐	☐	Barbiturates	☐	☐	Aspirin
☐	☐	Penicillin or other antibiotics	☐	☐	Sedatives	☐	☐	Other _____
☐	☐	Sulfa Drugs	☐	☐	Iodine			_____

9. WOMEN ONLY:

	YES	NO
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? ☐ ☐

11. Do you have or have you had any of the following?

YES	NO		YES	NO		YES	NO	
☐	☐	High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains
☐	☐	Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded
☐	☐	Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke
☐	☐	Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies
☐	☐	Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis
☐	☐	Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy
☐	☐	Low/High Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma
☐	☐	Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss
☐	☐	Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease
☐	☐	Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Mitral Valve Prolapse
☐	☐	Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems
☐	☐	AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Other _____
☐	☐	Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	_____

COMMENTS

Signature of Dentist Date

PATIENT DENTAL HISTORY

	YES	NO
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
a) Clicking?	☐	☐
b) Pain (joint, ear, side of face)?	☐	☐
c) Difficulty in opening or closing?	☐	☐
d) Difficulty in chewing?	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you had any orthodontic treatment?	☐	☐
13. Have you ever had prolonged bleeding following extractions?	☐	☐
14. Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
15. Have you ever had instructions on the care of your gums?	☐	☐

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE X _____ _____

PATIENT, PARENT OR GUARDIAN DATE

UNDERSTAND AND CONSENT (TO YOUR DENTAL TREATMENT)

FOR _____

Significant improvement in health, appearance and speech is most frequently achieved in the vast majority: of dental patients. But like any other treatment of the body, dental procedures (restorative, periodontal, orthodontic, surgical, endodontic or prosthodontic) have some inherent risks and limitations. These are seldom that serious as to contra-indicate the dental treatment recommended, but should be considered in making the decision to proceed with treatment. You are therefore urged to read the following information, ask us any questions that my come to mind, then (after you are completely satisfied with our explanations) consent to our treating you or your relative by signing this form. This is now a standard procedure in our office.

1. I have discussed my* medical and dental history with the doctor and have informed him of all allergies, and other serious problems that troubled me*. He has informed me of my present dental health and condition. 2. I understand the problem(s) that exist in my mouth. 3. I understand the doctor's treatment plan(s) and the procedure(s) involved: and the consequences of full, partial, or not treatment and the risks involved in proceeding with treatment and those risks involved in my refusing treatment. 4. The Treatment Plan which will benefit me the most was explained as well as alternative procedures. 5. I understand the purpose of treatment and the benefits we hope to achieve. I also understand that no one can predict the certainty of our treatment's result and I realize that I may be disappointed and that treatment might even be regarded as a failure in that condition could possibly worsen or that treatment would not satisfy my dentist's or my expectations. There is no guarantee of success, but of course it is our goal. 6. The fees associated with each treatment option were presented to me and fee payment schedules were discussed. 7. My responsibilities include making and keeping appointment on time, caring for my teeth and gums before, during and after treatment, following all other instructions given me and completing all financial obligations incurred. 8. I understand also that an unpredictable situation may occur during the doctor's treatment procedures and, within reason, do consent to any unspecified treatment the dentist deems necessary resulting from such unforeseen circumstances arising. 9. I realize that I need not consent to all these recommended treatment procedures and I have a right to alter this form accordingly within reason. 10. I have had the opportunity to ask any questions about my proposed treatment, and all questions have been answered to my complete satisfaction.

***If you are the patient's parents, the words "my" or "me" should be substituted with the words "the parents" or "the patient" respectively.**

The RISKS of course depend upon dental procedures involved. These procedures may include restorative dentistry, periodontal treatment, orthodontic therapy, surgery, endodontic and prosthodontic treatment as well as minimal exposure to X-Rays for necessary diagnostic purposes.

These risks may include: bad breath, tooth sensitivity to hot and/or cold, undesirable tooth movements, tissue inflammation and infection tooth mobility gum and bone recession, pain, swelling, bleeding, premature tooth loss, worsening of a periodontal condition, chewing or speech difficulty, oral opening restrictions,_____ pain disorder, unanticipated pulp chamber exposure necessitating pulp capping or tooth _____ requiring root canal therapy and all the risks involved therewith: unpredictable surgery and all its risks, possibly including tissue sloughing, implant rejection or an unanticipated apico-ectomy: an unpredictable procedure requiring local or general anesthesia and all the risks involved therewith.

Again, it is our intent to inform you of the myriad of possibilities that exist as potential problems. Most of these conditions would rarely occur. There may he other inherent risks not mentioned. You should be aware that these things can happen. If any of these conditions should develop, every effort will be made to properly treat the patient or refer him or her to the appropriate dentist or physician. Treatment of human biologic condition will never reach a state of perfection despite technological advancements. Your treatment depends on a close professional working relationship. Patients and their relatives should feel free to inquire about an aspect of their treatment. Understanding and cooperation are essential for the results we both seek.

I CERTIFY THAT I HAVE READ OR HAD READ TO ME THE CONTENTS OF THIS FORMAN D UNDERSTAND THE AUTHORIZATION THAT I AM ABOUT TO SIGN FOR PROPOSED TREATMENT, MEDICATION OR SURGERY DESCRIBED TO ME. I REALIZE AND ACCEPT THE RISKS OF SUBSTANTIAL HARM, IF ANY, AND THE LIMITATIONS INVOLVED IN THE HOPE OF OBTAINING THE DESIRED BENEFICIAL RESULTS, AND DO CONSENT TO MY DENTIST'S TREATMENT PLAN.

_____ _____

Signature of Patient, Parent, Guardian Date

Pima Dental Center for Cosmetic Dentistry
Bruce D. Schwartz D.D.S., P.C
10850 N. 90th St.
Scottsdale, AZ 85260
480-657-6357 phone
480-657-8951 fax

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____ _____
Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____
_____
_____
_____

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Welcome to Pima Dental….
How did you hear about our office?_____

Financial Policy

Thank you for choosing our office for your dental healthcare. We are unconditionally committed to provide you with the best in preventative approaches as well as the highest standards of treatment and dental procedures for solutions to your dental problems.
Our office does require your social security number for our records. Please understand that other than your insurance company (if applicable) all of your patient information is strictly confidential. To have your services comfortably affordable please review the following financial policies and select the type of account that best suits your needs:

AS SERVICES ARE RENDERED ( )
Patients are required to pay their estimated portion of treatment by cash, check or credit card at the time of service. We accept Visa, MasterCard and American Express.

CARE CREDIT PATIENT FINANCING ( )
Our patient coordinator will be happy to assist you with the application process.

UNDERSTANDING INSURANCE BENEFITS
As a courtesy for our patients with most dental insurance plans, we will happily submit dental claims to your insurance company for services rendered. Insurance companies are required by Arizona regulations to pay your claims within 30 days of submission. The estimated portion of your non-covered expenses will be due at the time of service**. Please be advised that your estimated out of pocket portion is just that, an estimate. We can never guarantee what an insurance company will and will not cover**. Since your contract is between you and your insurance company, any balances not paid in 45 days will be your responsibility. We will do everything possible to insure that the insurance company pays for any and all eligible expenses. By signing this policy, you are giving us permission to bill your insurance company for services rendered and allow us to review your treatment plan with them. **I understand completely that if my insurance company does not cover a service, for any reason, I am FULLY responsible.**

We do expect you to show up for all of the appointments which you have scheduled. We require 48 hours notice to make changes to your scheduled appointment(s). **If adequate notice is not given, or an appointment is failed you will be charged $50.00 per missed appointment**.

_____ _____
Responsible Party Date