AZ SPECIALTY DENTAL
IMPLANT & COSMETIC DENTISTRY

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ❑ M ❑ F Age _____ Birthdate _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____

Email _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Address _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Pharmacy _____ Phone _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name _____ Relation to Palient _____ Birthdate _____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ Stale _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Address _____

Contract# _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

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DENTAL HISTONY

What would you like us to do today? _____ Are you in dental discomfort today? _____
Former Dentist _____ Address _____
Dentist's Email _____ Phone _____
Date of last dental care _____ Date of last x-rays _____
Check(✔) yes or no if you have had problems with any of the following:

❑Y❑N Bad breath	❑Y❑N Food collection betweenteeth	❑Y❑N Periodontal treatment	❑Y❑N Sensitivity to sweets
❑Y❑N Bleeding gums	❑Y❑N Grinding or clenching teeth	❑Y❑N Sensitivity to cold	❑Y❑NSensitivity when biting
❑Y❑N Cicking or popping jaw	❑Y❑N Loose teeth or broken filings	❑Y❑N Sensitivity to hot	❑Y❑N Sores or growths in mouth

How often do you brush? _____ Floss? _____
How do you feel about the appearance of your teeth? _____
Do you wish your teeth were straighter? ❑Y ❑N Do you wish your teeth were whiter? ❑Y ❑N
Are you unhappy with any fillings, crowns or bridges? _____
Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑Y ❑N
Other information about your dental health or previous treatment_____

MEDICAL HISTORY

Physician's name_____ Phone _____
Date of last visit. Have you had any serious illnesses or operations? ❑Y ❑N
If yes, describe.
Are you currently under physician care? ❑Y ❑N If yes, describe _____
Have you ever had a blood transfusion? ❑Y ❑N If yes, give approximate dates _____
Have you ever taken Fen-Phen/Redux? ❑Y ❑N
Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. ❑Y ❑N
Do you smoke or use other tobacco/smokeless products? ❑Y ❑N Please circle all that apply: Cigarettes Cigars Vape Marijuana Chew Other _____
Women: Are you pregnant ? ❑Y ❑N Nursing? ❑Y ❑N Taking birth control pills? ❑Y ❑N
Check (✔) yes or no whether you have had any of the following:

❑Y ❑N AIDS/HIV Positive	❑Y ❑N Anaphylaxis	❑Y ❑N Cough, persistent	❑Y ❑N Cough up blood
❑Y ❑N Jaw pain	❑Y ❑N Kidney disease or malfunction		
❑Y ❑N Shingles	❑Y ❑N Shortness of breath	❑Y ❑N Skin rash	❑Y ❑N Spina Bifida
❑Y ❑N Anemia	❑Y ❑N Diabetes	❑Y ❑N Epilepsy	❑Y ❑N Fainting
❑Y ❑N Food allergies	❑Y ❑N Liver disease	❑Y ❑N Material allergies (latex, w0ol, metal, chemicals)	
❑Y ❑N Arthritis, Rheumatism	❑Y ❑N Artificial heart valves	❑Y ❑N Artificial joints	❑Y ❑N Stroke
❑Y ❑N Surgical implant	❑Y ❑N Swelling of feet or ankles	❑Y ❑N Asthma	❑Y ❑N Glaucoma
❑Y ❑N Mitral valve prolapse	❑Y ❑N Atopic (allergy prone)	❑Y ❑N Headaches	❑Y ❑N Nervous problems
❑Y ❑N Pacemaker / Heart surgery	❑Y ❑N Back problems	❑Y ❑N Heart murmur	❑Y ❑N Thyroid disease or
❑Y ❑N Blood disease	❑Y ❑N Cancer	Describe _____	❑Y ❑N Heart problems
❑Y ❑N Tobacco habit	❑Y ❑N Tonsillitis	❑Y ❑N Psychiatric care	❑Y ❑N Rapid weight gain or loss
❑Y ❑N Tuberculosis	❑Y ❑N Radiation treatment	❑Y ❑N Respiratory disease	❑Y ❑N Rheumatic/Scarlet fever
❑Y ❑N Chemical dependency	❑Y ❑N Chemotherapy	❑Y ❑N Hemophilia Abnormal bleeding	❑Y ❑N Herpes
❑Y ❑N Hepatitis	❑Y ❑N High blood pressure	❑Y ❑N Circulatory problems	❑Y ❑N Ulcer/Colitis
❑Y ❑N Cortisone treatments	❑Y ❑N Venereal disease		

Are you currently taking any medications? If yes, list all: _____
Do you have any drug allergies? If yes, list all: _____

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status,I will inform the dentist.
I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. authorize the use of this signature on all insurance submissions.
I authorize the dentist to release allinformation necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whelher or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.