Arizona Center for Implant, Facial, and Oral Surgery

Patient Information

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Minor

First Name_____ Middle Initial_____ Last Name_____

SS#_____ Date of Birth_____ Age_____ ☐ Male ☐ Female

Address_____ Apt#_____ City_____ State_____ Zip_____

Home Phone (____) _____ Cell Phone (____) _____ Full Time student? **Yes / No**

Employer_____ Email_____

Name of parent or legal guardian accompanying minor_____
FIRST NAME LAST NAME

DOB_____ SS#_____ DL#_____ State_____

Address_____ Apt#_____ City_____ State_____ Zip_____

Relationship to minor_____ Home Phone(____) _____ Cell Phone(____) _____

***** For children under 18 years of age, the legal guardian or parent accompanying the child to this appointment is deemed the responsible party for the payment on this account.*****

Emergency Contact_____ Phone (____) _____ Relationship_____

I authorize the doctors or staff to discuss my care and/or treatment with my primary emergency contact or person listed above._____(initial)

Referred by_____ **Patient's Dentist**_____
FIRST NAME LAST NAME FIRST NAME LAST NAME

Primary Dental Insurance

Insurance Company_____ Insurance Phone (____) _____

Insured_____ SS/ID#_____ DOB_____
FIRST NAME LAST NAME

Insured Address_____ Apt#_____ City_____ State_____ Zip_____

Employer_____ Group #_____ Relationship to Patient_____

Secondary Dental Insurance

Insurance Company_____ Insurance Phone (____) _____

Insured_____ SS/ID#_____ DOB_____
FIRST NAME LAST NAME

Insured Address_____ Apt#_____ City_____ State_____ Zip_____

Employer_____ Group#_____ Relationship to Patient_____

X_____ _____
Patient Signature (or parent/guardian, if patient is a minor) Date

Arizona Center for Implant, Facial, and Oral Surgery

FINANCIAL POLICY AND PRACTICE NOTICES

Privacy Practice Acknowledgement for All Patients:

_____(Please Initial) **HIPAA Notice**: You have the right to read our Notice of Privacy Practices before you decide to initial this section. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices to follow federal/state guidelines. You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to our office. Please understand that revocation of this Consent will NOT affect any action we took in reliance on this consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this consent.

Financial Agreement:

_____(Please Initial) I understand payment (including co-payment if billing insurance for covered procedure) is due at the time services are rendered. Cash, Debit, Credit Cards (subject to 1.5% processing fee) Money Order, Care Credit, and Checks are accepted methods of payment.

_____(Please Initial) I understand that upon failure to pay for services rendered, my account (including all personal information) may be sent to a collection agency. An additional collection agency fee of 30% will be applied to the account's outstanding balance.

For Patients with Insurance Only:

_____(Please Initial) ASSIGNMENT AND RELEASE: I hereby authorize payment to **Arizona Center for Implant, Facial and Oral Surgery** for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the use of this signature on all insurance submissions. I further authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason my behalf, should the need arise.

_____(Please Initial) If there is insurance, the balance is due within 60 days from the date of service or when insurance pays, whichever is first. Pursuant to the Federal Consumer Credit Protection Act, we disclose that no interest charge will be applied if this agreement is adhered to. If the terms of this agreement are not met, interest charges of 1.5% per month is to be adhered to the remaining balance (18% per year) in addition to the entire balance becoming due.

For Medicare Beneficiaries Only:

_____(Please Initial) I have reviewed agree to the terms of the Private Contract (dated 7/2014) and understand Medicare will not be billed for any services rendered.

_____ _____

Patient Signature (OR legal representative; parent/guardian, if patient is a minor) Date

Arizona Center for Implant, Facial, and Oral Surgery

Patient Name:_____

Pharmacy:_____Phone:( )_____

Family Physician:_____
FIRST NAME LAST NAME

Phone:( )_____

Specialist:_____
FIRST NAME LAST NAME

Answer all questions by circling Yes or No

1. Are you in good health? Yes or No

2. Has there been any change in your health history in the last year? Yes or No

3. Date of last physical exam_____

4. Are you now under a physician's care for any particular illness? Yes or No

5. Have you **ever** had any serious illness, operations, or hospitalizations? If so please describe.

6. Height:_____Weight:_____

7. Do you have or have ever had any of the following?

Rheumatic Fever	Yes	or	No
Rheumatic heart disease	Yes	or	No
Congenital heart disease	Yes	or	No
Heart attack	Yes	or	No
Heart trouble	Yes	or	No
Heart murmur	Yes	or	No
Coronary artery disease	Yes	or	No
Angina	Yes	or	No
High blood pressure	Yes	or	No
Stroke	Yes	or	No
Palpitations	Yes	or	No
Heart surgery	Yes	or	No
Pacemaker	Yes	or	No
MVP (mitral valve prolapse)	Yes	or	No
Asthma	Yes	or	No
Emphysema	Yes	or	No
Chronic cough	Yes	or	No
Bronchitis	Yes	or	No
Pneumonia	Yes	or	No
Tuberculosis	Yes	or	No
Shortness of breath	Yes	or	No
Chest pain	Yes	or	No
Severe coughing	Yes	or	No
Seizures	Yes	or	No
Convulsions	Yes	or	No
Epilepsy	Yes	or	No
Fainting	Yes	or	No
Dizziness	Yes	or	No
Bleeding disorder	Yes	or	No
Anemia	Yes	or	No
Bleeding tendency	Yes	or	No
Blood transfusion	Yes	or	No
Do you bruise easily?	Yes	or	No
Jaundice	Yes	or	No
Hepatitis	Yes	or	No
Kidney disease	Yes	or	No
Diabetes	Yes	or	No
Thyroid Disease	Yes	or	No
Arthritis	Yes	or	No
Stomach ulcers or colitis	Yes	or	No
COPD	Yes	or	No
Glaucoma	Yes	or	No
Implants anywhere in body	Yes	or	No
Radiation or chemotherapy for cancer	Yes	or	No

8. ARE YOU USING ANY OF THE FOLLOWING?

Antibiotics	Yes	or	No
Blood thinners	Yes	or	No
Aspirin	Yes	or	No
Motrin	Yes	or	No
Aleve	Yes	or	No
Ibuprofen	Yes	or	No
High blood pressure meds	Yes	or	No
Steroids (cortisone, ect.)	Yes	or	No
Tranquilizers	Yes	or	No
Insulin or Oral anti-diabetic drugs	Yes	or	No
Nitroglycerine	Yes	or	No
Other heart drugs	Yes	or	No
Bisphosphonates (Fosamax, Reclast, Boniva, Zometa, or other bone strengtheners)	Yes	or	No
Cholesterol Meds	Yes	or	No

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Please list any and all medications taken, including prescriptions, over-the-counter medications, herbal, or holistic remedies, vitamins, or minerals:

9. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:

Local anesthesia (Novocain, etc)	Yes	or	No
Penicillin or other antibiotics	Yes	or	No
Sedatives	Yes	or	No
Barbiturates	Yes	or	No
Aspirin or Ibuprofen	Yes	or	No
Codeine or other pain killers	Yes	or	No
Latex or rubber products	Yes	or	No

Other allergies or reactions? Please list:

10. Do you smoke or chew tobacco? Yes or No
If so, how much per day? _____

11. Is there any past history of alcohol or chemical use? Yes or No

12. Have you or any immediate family member had any dependency or emotional disorder that may affect the care we provide to you? Yes or No

13. Have you or any immediate family member had problems associated with intravenous anesthesia? Yes or No

14. Do you have any disease, condition, or other problem not listed so far that you believe the doctor should be aware of? Yes or No

15. Do you wish to talk to the doctor privately about anything? Yes or No

16. FOR WOMEN ONLY:

Are you pregnant, or is there **any chance** you might be pregnant? Yes or No

Are you nursing? Yes or No

If you are using oral contraceptives, it is important to understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control, after the course of antibiotics or other medications is complete. Please consult your physician for further guidance.

_____

***I understand the importance of a truthful health history to assist the doctor in providing the best care possible. I have had the opportunity to discuss my health history with the doctor.**

X_____**Date:**_____

Patient Signature (or person completing the health history)

X_____**Date:**_____

Doctor Signature (upon reviewing health history)

Updates Only:

I have reviewed my medical history form and everything is correct and/or I have noted any changes.

X_____Date:_____