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?_____

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

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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 ☐ No ☐
2. Has there been any change in your health history in the last year? Yes ☐ No ☐
3. Date of last physical exam_____
4. Are you now under a physician's care for any particular illness? Yes ☐ 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 ☐	No ☐
Rheumatic heart disease	Yes ☐	No ☐
Congenital heart disease	Yes ☐	No ☐
Heart attack	Yes ☐	No ☐
Heart trouble	Yes ☐	No ☐
Heart murmur	Yes ☐	No ☐
Coronary artery disease	Yes ☐	No ☐
Angina	Yes ☐	No ☐
High blood pressure	Yes ☐	No ☐
Stroke	Yes ☐	No ☐
Palpitations	Yes ☐	No ☐
Heart surgery	Yes ☐	No ☐
Pacemaker	Yes ☐	No ☐
MVP (mitral valve prolapse)	Yes ☐	No ☐
Asthma	Yes ☐	No ☐
Emphysema	Yes ☐	No ☐
Chronic cough	Yes ☐	No ☐
Bronchitis	Yes ☐	No ☐
Pneumonia	Yes ☐	No ☐
Tuberculosis	Yes ☐	No ☐
Shortness of breath	Yes ☐	No ☐
Chest pain	Yes ☐	No ☐
Severe coughing	Yes ☐	No ☐
Seizures	Yes ☐	No ☐
Convulsions	Yes ☐	No ☐
Epilepsy	Yes ☐	No ☐
Fainting	Yes ☐	No ☐
Dizziness	Yes ☐	No ☐
Bleeding disorder	Yes ☐	No ☐
Anemia	Yes ☐	No ☐
Bleeding tendency	Yes ☐	No ☐
Blood transfusion	Yes ☐	No ☐
Do you bruise easily?	Yes ☐	No ☐
Jaundice	Yes ☐	No ☐
Hepatitis	Yes ☐	No ☐
Kidney disease	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐
Thyroid Disease	Yes ☐	No ☐
Arthritis	Yes ☐	No ☐
Stomach ulcers or colitis	Yes ☐	No ☐
COPD	Yes ☐	No ☐
Glaucoma	Yes ☐	No ☐
Implants anywhere in body	Yes ☐	No ☐
Radiation or chemotherapy for cancer	Yes ☐	No ☐

8. ARE YOU USING ANY OF THE FOLLOWING?

Antibiotics	Yes ☐	No ☐
Blood thinners	Yes ☐	No ☐
Aspirin	Yes ☐	No ☐
Motrin	Yes ☐	No ☐
Aleve	Yes ☐	No ☐
Ibuprofen	Yes ☐	No ☐
High blood pressure meds	Yes ☐	No ☐
Steroids (cortisone, ect.)	Yes ☐	No ☐
Tranquilizers	Yes ☐	No ☐
Insulin or Oral anti-diabetic drugs	Yes ☐	No ☐
Nitroglycerine	Yes ☐	No ☐
Other heart drugs	Yes ☐	No ☐
Bisphosphonates (Fosamax, Reclast, Boniva, Zometa, or other bone strengtheners)	Yes ☐	No ☐
Cholesterol Meds	Yes ☐	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 ☐	No ☐
Penicillin or other antibiotics	Yes ☐	No ☐
Sedatives	Yes ☐	No ☐
Barbiturates	Yes ☐	No ☐
Aspirin or Ibuprofen	Yes ☐	No ☐
Codeine or other pain killers	Yes ☐	No ☐
Latex or rubber products	Yes ☐	No ☐

Other allergies or reactions? Please list:

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

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

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

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

16. FOR WOMEN ONLY:

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

Are you nursing? Yes ☐ 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:_____