WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

Jones Family Dentistry • 7350 McClintock, Suite 102 • Tempe, Arizona 85283 • (480) 831-9874

About You

Today's Date: _____

Name: _____ I prefer to be called: _____ ❑ Male ❑ Female
Last First Mi Mr Mrs Ms Dr

Birthdate: ___/___/___ Age: _____ Social Security #: _____ ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Address: _____
Street City State Zip

E-mail Address: _____

Home Phone #: (_____)_____ Cell/Other #: (_____)_____ Work Phone #: (_____)_____ Ext: ____ Driver's License #: _____

Best number to call? _____ **Whom may we thank for referring you?** _____

Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street/PO Box City State Zip

Neighbor or Relative not living with you

His / Her Name: _____ Relation: _____ Work Phone #: (_____)_____ Home Phone #: (_____)_____

Address: _____
Street City State Zip

Spouse Information

His / Her Name: _____ Birthdate: ___/___/___

Employer: _____ Work Phone #: (_____)_____ Ext: _____ Cell/Other #: (_____)_____

Insurance Information

Primary Insurance Dental Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (_____)_____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's ID #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

Secondary Insurance Dental Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (_____)_____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's ID #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

CONTINUED ON BACK

Dental History

Why have you come to the dentist today? _____

_____

Are you currently in pain? ❑ Yes ❑ No

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

Your current dental health is ❑ Good ❑ Fair ❑ Poor

Do you floss daily? ❑ Yes ❑ No Brush daily? ❑ Yes ❑ No

Type of bristles on your toothbrush? ❑ Hard ❑ Medium ❑ Soft

Do your gums ever bleed? ❑ Yes ❑ No Ever Itch? ❑ Yes ❑ No

Have you ever had periodontal disease? ❑ Yes ❑ No

Are your teeth sensitive to heat, cold, or anything else? _____

Do you have mobility in your teeth? ❑ Yes ❑ No

Do you still have wisdom teeth? ❑ Yes ❑ No

Previous / Present Dentist: _____ Last Visit Date: _____
(Please Circle)

Would you like fresher breath? ❑ Yes ❑ No Whiter teeth? ❑ Yes ❑ No

Are you happy with the way your smile looks? ❑ Yes ❑ No

If not, what would you change? _____

_____

Medical History

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: _____

Address: _____
Street

_____
City State Zip

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 smoke or use tobacco in any other form? ❑ Yes ❑ No

Have you ever taken Phen-Fen, Redux or Pondimin? ❑ Yes ❑ No

Have you ever taken Fosamax, or any other bisphosphonate? ❑ Yes ❑ No

For Women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Unsure ❑ Yes ❑ No

Week #: _____ Are you nursing? ❑ Yes ❑ No

Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Congenital Heart Defect	Y N Heart Attack	Y N Lupus	Y N Sinus Problems
Y N Alcohol Abuse	Y N Diabetes	Y N Heart Murmur	Y N Mitral Valve Prolapse	Y N Steroid Therapy
Y N Anemia	Y N Difficulty Breathing	Y N Heart Surgery	Y N Pacemaker	Y N Stroke
Y N Arthritis	Y N Drug Abuse	Y N Hemophilia	Y N Persistent Cough	Y N Thyroid Problems
Y N Artificial Bones/Joints	Y N Emphysema	Y N Hepatitis A, B, C	Y N Psychiatric Problems	Y N Tonsillitis
Y N Artificial Valves	Y N Epilepsy	Y N Herpes	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Asthma	Y N Fainting Spells	Y N High Blood Pressure	Y N Rheumatic Fever	Y N Ulcers
Y N Blood Transfusion	Y N Fever Blisters	Y N HIV+/AIDS	Y N Scarlet Fever	Y N Venereal Disease
Y N Cancer	Y N Glaucoma	Y N Kidney Problems	Y N Seizures	
Y N Chemotherapy	Y N Hay Fever	Y N Liver Disease	Y N Shingles	
Y N Colitis	Y N Headaches	Y N Low Blood Pressure	Y N Sickle Cell Disease	

Please list any serious medical condition(s) that you have experienced: _____

_____

Are you taking any prescription/over the counter drugs? ❑ Yes ❑ No If yes, please list each one: _____

_____

Are you allergic to any of the following?

Y N Aspirin	Y N Codeine	Y N Erythromycin	Y N Latex	Y N Sedatives	Y N Tetracycline
Y N Barbiturates	Y N Dental Anesthetics	Y N Jewelry / Metals	Y N Penicillin	Y N Sulfa Drugs	Y N Other

Please list anything additional that causes allergic reactions: _____

_____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.
I have received a copy of this offices Notice of Privacy Practices.

_____ _____
Signature Date

JONES FAMILY DENTISTRY

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and realize that your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

Payments

- All payments are due at the time of service. We accept cash, personal checks & credit cards (Visa, MasterCard, American Express, and Discover).

For Our Patients with Dental Insurance

- Our office is committed to helping patients maximize their benefits. We are happy to manage all claim submission and will follow up on your behalf.

- Because insurance policies vary greatly, we can estimate your coverage but cannot guarantee it. Your estimated portion will be due at the time of service, and any unpaid balance will be billed to you after 45 days.

Optional Payment Terms

1. Full Pay Discount: We offer a 5% discount for all treatment that is paid in full prior to your dental appointment. For our patients with insurance who choose this option, we will file your insurance claim and instruct them to send payment directly to you.

2. No-Interest Payments: By arrangement with Care Credit, we offer our patients, upon approval, an interest-free term loan for up to 12 months. Please ask for an application.

Cancellation Policy

- We ask for at least 24 hours advance notice for canceling or rescheduling an appointment; otherwise a $50 fee may be assessed to your account.

Interest Charges

- After 30 days, all unpaid balances will be subject to an 18% finance charge.

I have read and understood the above statements:

_____	_____	_____
Please Print Name	Signature	Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

This office's Notice of Privacy Practices has been made available to me.

_____	_____	_____
Please Print Name	Signature	Date