OCOTILLO LAKES
DENTAL HEALTH

(480) 878-5570
3200 S Alma School Rd Ste 103
Chandler, AZ 85248

WELCOME

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

1 ABOUT YOU

Name _____
Preferred Name _____ ☐ Male ☐ Female
☐ Single ☐ Married ☐ Other
Birthdate ___/___/___ Age _____ SS# _____
Address _____
City _____ State _____ Zip _____
Email _____
Home # _____ Work # _____
Mobile # _____ Fax # _____
Whom may we thank for referring you? _____
Other family members seen by us _____
_____
Employer _____ Employer Ph# _____
Employee Address _____
How long employed there? _____

2 ACCOUNT INFO

PERSON RESPONSIBLE FOR ACCOUNT
(If under 18)

Name _____ Relation _____
Home # _____ Work # _____
Mobile # _____ Birthdate _____
Email _____
Billing Address _____
City _____ State _____ Zip _____

3 SPOUSE INFO

Name _____
Home # _____ Work # _____
Mobile # _____ Birthdate _____
Email _____

4 DENTAL INSURANCE

Provider Name _____
Provider Address _____
City _____ State _____ Zip _____
Group # _____
Insured's Name _____ Relation _____
Insured's Birthdate _____ Insured's I.D.# _____
Insured's Employer _____ Insured's Ph# _____

SECONDARY INSURANCE

Provider Name _____
Provider Address _____
City _____ State _____ Zip _____
Group# _____
Insured's Name _____ Relation _____
Insured's Birthdate _____ Insured's ID # _____
Insured's Employer _____ Insured's Ph# _____

5 MEDICAL

Do you have a personal physician? ☐ Yes ☐ No
Physician's Name _____
Phone # _____ Last visit date _____
Are you currenty under the care of a physician? ☐ Yes ☐ No
Please explain _____
Pharmacy _____ Phone _____ Location _____

IN THE EVENT OF AN EMERGENCY,
WHO SHOULD WE CONTACT?

Name _____ Relation _____
Home # _____ Work# _____

Thank you for filling out this form completely. It will allow us to serve you more effectively. If you have a question at any time, please ask us.
We are happy to help.

OCOTILLO LAKES
DENTAL HEALTH

(480) 878-5570
3200 S Alma School Rd Ste 103
Chandler, AZ 85248

5b MEDICAL HISTORY

Name _____

Your current physical condition ☐ Good ☐ Fair ☐ Poor
Do your smoke or use tobacco in any form? Yes No
Are you taking any prescription/over-the-counter or herbal supplement drugs? ☐ Yes ☐ No

Please list each one _____

_____

_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Yes	No	Abnormal Bleeding	Yes	No	Herpes/Fever/Blisters
Yes	No	Alcohol/Drug Abuse	Yes	No	High Blood Pressure
Yes	No	Anemia	Yes	No	HIV+ / AIDS
Yes	No	Arthritis	Yes	No	Hospitalized for any reason
Yes	No	Artificial Bones, Joints, or Valves	Yes	No	Kidney Problems
Yes	No	Asthma	Yes	No	Liver Disease
Yes	No	Blood Transfusion	Yes	No	Low Blood Pressure
Yes	No	Cancer/Chemotherapy	Yes	No	Lupus
Yes	No	Colitis	Yes	No	Mitral Valve Pressure
Yes	No	Congenital Heart Defect	Yes	No	Pacemaker
Yes	No	Diabetes	Yes	No	Psychiatric Problems
Yes	No	Difficulty Breathing	Yes	No	Radiation Treatment
Yes	No	Emphysema	Yes	No	Rheumatic/Scarlet Fever
Yes	No	Epilepsy	Yes	No	Seizures
Yes	No	Fainting Spells	Yes	No	Shingles
Yes	No	Frequent Headaches	Yes	No	Sickle Cell Disease
Yes	No	Glaucoma	Yes	No	Sinus Problems
Yes	No	Hay Fever	Yes	No	Sleep Disorder
Yes	No	Heart Attack	Yes	No	Stroke
Yes	No	Heart Murmur	Yes	No	Thyroid Problems
Yes	No	Heart Surgery	Yes	No	Tuberculosis (TB)
Yes	No	Hemophilia	Yes	No	Ulcers
Yes	No	Hepititis A/B/C	Yes	No	Venereal Disease

Please list any medical condition(s) that you have ever had

_____

_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Yes	No	Aspirin	Yes	No	Erythromyein	Yes	No	Penicillin
Yes	No	Codeine	Yes	No	Jewelry/Metals	Yes	No	Tetraeyeline
Yes	No	Dental Anesthetics	Yes	No	Latex	Yes	No	Other

Please list any other drugs/materials that you are allergic to.

_____

_____

FOR WOMEN ONLY

Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

6 HISTORY

Has your Doctor told you that you require antibiotics? before dental treatment? ☐ Yes ☐ No

Do you or have you ever experienced pain/discomfort in your Jaw Joint (TMJ/TMD)? ☐ Yes ☐ No

Do you have sleep apnea? ☐ Yes ☐ No

Have you ever worn a CPAP? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

How many times a week do you clean between your teeth?

How many times a day do you brush? _____

Type of toothbrush bristles? ☐ Hard ☐ Medium ☐ Soft

What type of toothbrush do you use? ☐ Manual ☐ Electric

If electric, which brand? _____

Does any aspect of having dentistry done make you nervous or scared? ☐ Yes ☐ No

Would you like to learn more about sedation options available? ☐ Yes ☐ No

7 DISCLAIMER

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature Date

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED

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

OCOTILLO LAKES
DENTAL HEALTH

(480) 878-5570
3200 S Alma School Rd Ste 103
Chandler, AZ 85248

Welcome. **We're glad you're here.**

To better serve you, please take just a couple of minutes to answer the following questions, Thanks!

Please check any of the following problems that apply to you:

- ◯ Sensitivity (hot, cold, or sweet)
  If so, which teeth?
- ◯ Headaches, earaches, neck pain
- ◯ Teeth or fillings breaking
- ◯ Grinding or clenching teeth
- ◯ Bleeding, swollen, or irritated gums
- ◯ Loose, tipped or shifted teeth
- ◯ Bad breath

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

- ◯ Dentures
- ◯ Partial dentures
- ◯ Periodontal (gum) treatments

Please share the following approximate dates:

Your last cleaning _____

You last oral cancer screening _____

You last complete x-rays _____

Who was your previous dentist?

Name _____

City _____ State _____

Phone _____

What are the most important things to you about your smile and dental health?

If you could whiten your teeth, at a cost that anyone could afford, would you like to?

Do you smoke or use tobacco?

◯ Yes ◯ No

If yes, how much? and, for how long?

If you could change your smile, would you:
(please check all that apply)

- ◯ Make you teeth whiter
- ◯ Make you teeth straighter
- ◯ Close spaces between teeth
- ◯ Replace black metal fillings with tooth-colored restorations
- ◯ Repair chipped teeth
- ◯ Replace missing teeth
- ◯ Replace old crowns that don't match
- ◯ Have a smile makeover

On a scale of 1 to 5 with 5 being the highest rating:

(please circle the number that best applies)

How important is your dental health to you?

1 2 3 4 5

How would you rate your current dental health?

1 2 3 4 5

Where do you want your dental health to be?

1 2 3 4 5

Why did you leave your previous dentist?

What is the most important thing to you about you dental visit today?

OCOTILLO LAKES
DENTAL HEALTH

(480) 878-5570
3200 S Alma School Rd Ste 103
Chandler, AZ 85248

Consent for Services

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I aknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deems appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to thrid-party insurance carriers, payers and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance of my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I will be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:
Signature: _____ Date: _____

Relationship to patient: _____

Financial Agreement

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. The office will submit the patient's insurance forms and assist in making collections from insurance companies. Anu insurance payment will be credited to the patient's account. Any balance not paid by the insurance will be the patients responsibility.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services renderred to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that a waver of any breach of any condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss the statement or my treatment.
I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian (responsible party)

Signature: _____ Date: _____

Relationship to patient: _____