FLOSSED
FAMILY DENTISTRY

Welcome

We are pleased to welcome you to our prarctice. Please take a few minutes to flll 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 maintnining your dental health.

Patient Information

Name
(Last) (MI) (First)

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. I prefer to be called:

Birthdate: SS#:

Home Address:

City: State: Zip:

☐ Single: ☐ Married: ☐ Divorced: ☐ Widowed: ☐ Separated:

Home Phone: Mobile:

Email:

Employer: Occupation:

Please check all methods we may use to contact you:
☐ Home ☐ Mobile ☐ Email

Whom may we thank for referring you?

Other family members seen by us:

Responsible Party's Information

His/Her Name:
(First) (MI) (Last)

Birthdate: SS#:

Employer: Occupation:

Home Phone: Mobile:

Work Phone: Email:

Emergency Contact

In the event of an emergency, who would you like us to contact?

Name:

Relationship:

Home Phone: Mobile:

Work Phone: Email:

Dental Insurance

Primary Dental Insurance

Name of Insurance Co:

Address:

Phone #:

Subscriber ID/Policy #:

Group #:

Insured's Name:

Relation:

Insured's Birthday: Insured's SS#:

Insured's Employer:

Additional Dental Insurance

Name of Insurance Co:

Address:

Phone #:

Group #:

Insured's Name:

Relation:

Insured's Birthday: Insured's SS#:

Insured's Employer:

Preferred Pharmacy

Name of Pharmacy:

Address:

Phone #:

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Medical History

Patient Information Name: Date of Birth:

Physician's Name: Physician's Phone #:

Date of last visit: Have you had any serious illnesses or operations? ☐ Yes ☐ No

If yes, describe

Are you currently under physician care? ☐ Yes ☐ No If yes, describe

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates

Have you ever taken Fen-Phen/Redux? ☐ Yes ☐ No

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. ☐ Yes

Do you smoke or use other tobacco/smokeless products? ☐ Yes ☐ No Check all that apply: ☐ Cigarettes ☐ Cigars ☐ Vape ☐ Marijuana ☐ Chew

Other

Women: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No
Taking birth control pills? ☐ Yes ☐ No

Check (✓) yes or no whether you have had any of the following:

☐ Yes	☐ No	AIDS/HIV Positive	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Pacemaker/Heart surgery
☐ Yes	☐ No	Anaphylaxis	☐ Yes	☐ No	Fainting	☐ Yes	☐ No	Psychiatric care
☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Food allergies	☐ Yes	☐ No	Rapid weight gain loss
☐ Yes	☐ No	Arthritis, Rheumastism	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Radiation treatment
☐ Yes	☐ No	Artificial heart valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Respiratory disease
☐ Yes	☐ No	Artificial Joints	☐ Yes	☐ No	Heart murmur	☐ Yes	☐ No	Rheumatic/Scarlet fever
☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Heart problems	☐ Yes	☐ No	Shingles
☐ Yes	☐ No	Atopic (allergy prone)	Describe:			☐ Yes	☐ No	Shortness of breath
☐ Yes	☐ No	Back problems	☐ Yes	☐ No	Hemophilia/Abnormal bleeding	☐ Yes	☐ No	Skin rash
☐ Yes	☐ No	Blood disease	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Spina Bifida
☐ Yes	☐ No	Cancer	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Stroke
☐ Yes	☐ No	Chemical dependency	☐ Yes	☐ No	High blood pressure	☐ Yes	☐ No	Surgical implant
☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No	Jaw pain	☐ Yes	☐ No	Swelling of feet or ankles
☐ Yes	☐ No	Circulatory problems	☐ Yes	☐ No	Kidney disease or malfunction	☐ Yes	☐ No	Thyroid disease of malfunction
☐ Yes	☐ No	Cortisone treatments	☐ Yes	☐ No	Liver disease	☐ Yes	☐ No	Tobacco habit
☐ Yes	☐ No	Cough, persistent	☐ Yes	☐ No	Material allergies	☐ Yes	☐ No	Tonsillitis
☐ Yes	☐ No	Cough up blood			(**latex**, wool, metal, chemicals)	☐ Yes	☐ No	Tuberculosis
☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Mitral valve prolapse	☐ Yes	☐ No	Ulcer/Colitis
			☐ Yes	☐ No	Nervous problems	☐ Yes	☐ No	Venereal disease

Other

Does patient have drug allergies? If yes, list all:

Is patient currently taking any medications? If yes, list all:

Medication	Dosage	Reason for Taking Medication

Patient Signature: Date:

Doctor's Signature: Date:

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Dental History

What would you like us to do today? _____

Are you in dental discomfort today? ☐ Yes ☐ No

Former Dentist: _____ 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:

☐ Yes ☐ No Bad breath	☐ Yes ☐ No Grinding or clenching teeth	☐ Yes ☐ No Sensitivity to hot
☐ Yes ☐ No Bleeding gums	☐ Yes ☐ No Loose teeth or broken fillings	☐ Yes ☐ No Sensitivity to sweets
☐ Yes ☐ No Clicking or popping jaw	☐ Yes ☐ No Periodontal treatment	☐ Yes ☐ No Sensitivity when biting
☐ Yes ☐ No Food collection between teeth	☐ Yes ☐ No Sensitivity to cold	☐ Yes ☐ No Sores or growths in mouth

How often do you brush? _____ How often do you floss? _____

How do you feel about the appearance of your teeth? _____

Do you wish your teeth were straighter? ☐ Yes ☐ No

Do you wish your teeth were whiter? ☐ Yes ☐ No

Are you unhappy with any fillings, crowns or bridges? ☐ Yes ☐ No

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Yes ☐ No

Other information about your dental health or previous treatment _____

I have reviewed the information on the questionnaires, 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. I authorize the use of the signature on all insurance submissions.

I authorize the dentis to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: Date:

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

Doctor's Signature: Date:

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1735 W. Hunt Hwy. Ste. C-103
San Tan Valley, AZ 85143
Phone: (480) 581-7681

HIPAA CONSENT FORM

Patient Name (please print): _____ Date: _____

Patient DOB: _____

HIPAA- Notice of Privacy Practices
HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of the notice Privacy Practice is to explain how Flossed Family Dentistry may use or disclose your healthcare information. The notice also explains the rights that you are guaranteed under HIPAA regulations. Flossed Family Dentistry is required by the HIPAA Privacy Rule to distribute this notice to you and obtain acknowledgement that you have received the notice. Signing below indicates that you have received the Notice of Privacy Practices. I hereby acknowledge that I have received or requested to receive a copy of Flossed Family Dentistry Notice of Privacy Practices.

_____

Patient Signature (or Guardian)

Permission to Share Medical/Dental Information:

(including a spouse; optional- you may leave this BOTTOM portion blank)

My medical/dental information may be obtained and/or exchanged written or verbally to:

_____

(Printed Name and Relationship)

_____ _____

Patient Signature (or Guardian) **Date**

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Patient Name (please print): _____

Date: _____

ELECTRONIC BILLING - I consent for Flossed Family Dentistry to send billing information to:
☐ Text ☐ Email ☐ Both

FINANCIAL AGREEMENT - Payment in full / estimated co-insurance for all charges is required at time of treatment, unless prior arrangements have been made.

INSURANCE FILING - You, the patient, are ultimately responsible for payment in full on your account, not the insurance company. We do, however file dental insurance claims ***as a courtesy*** for our patients. We can only make estimates regarding your insurance benefits based on the information provided by you and the insurance company. In the event your insurance company does not pay as much as expected, the remaining balance is due and payable immediately by
you, the patient.

ASSIGNMENT OF INSURANCE BENEFITS - I/we hereby assign directly to Flossed Family Dentistry insurance benefits other wise payable to me/us. I/we herby authorize the release of any information relating to any claims. I/we are financially responsible for charges not paid by the assignment.

_____

Responsible Party Signature

DELINQUENT ACCOUNTS - All delinquent accounts (30 days or older) are subject to reasonable service charges and/or legal interest rates.

COLLECTION POLICY - In the event your account is turned over to a collection agency for non-payment or other delinquency, you will be responsible for payment of any collection cost and/or attorney fees, in addition to the balance owed. Any account turned over to a Collection Agency forfeits any past special fees and/or discounts. Such special fees and/or discounts will be reversed and you will be responsible for payment of regular fee for the procedures at the time of service.

CANCELLATION POLICY - An appointment is an agreement between you and our office. Our part involves reserving the dentist, staff, and office time for you. Due to the ever-increasing demand for our services, we kindly request that if you must reschedule and appointment, please extend us the courtesy of ***48-hour*** notice. This courtesy will make it possible to give your reserved time to another patient. Any failed appointment or cancellation with less than ***48-hour*** notice may be subject to a $50 fee. While we realize that emergencies do happen and are not anticipated, all efforts to notify us are greatly appreciated.

_____

Responsible Party Signature

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I have received/offered a copy of the office's Notice of Privacy Practices. I understand that I have aright to refuse to sign this acknowledgment.

_____

Responsible Party Signature