Prime Dental

Sarah Kym, DDS
www.primedentalaz.com
Tel : 520 886 2822
1840 N Craycroft Rd
Tucson, AZ 85722

PATIENT INFORMATION

Date: ______________ ☐New Patient ☐Update

Patient: ______________________________

First MI Last Preferred Title

☐Male ☐Female ☐Child* ☐Student** ☐Single ☐Married ☐Divorced ☐Widowed

*If Child, provide parent/guardian name(s) below:

____

Parent/Guardian Name(s)

**If Student, please complete: ☐Full-time ☐Part-time

____

School/Location

Patient Date of Birth: ______________ Patient SSN: ______________

Address: ______________________________

Address Line 1

______________________________ Cell: ______________

Address Line 2 Work: ______________

______________________________ Other: ______________

City ST ZIP Code

E-Mail: ______________________________

Referral? ☐Yes ☐ No Referred by: ______________________________

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

______________________________ Tel: ______________

Name Relationship

EMPLOYMENT INFORMATION

Employer: ______________ Occupation: ______________

Address: ______________________________

Address Line 1 Work: ______________ X

______________________________ Direct: ______________

Address Line 2 Other: ______________

______________________________ Pager: ______________

City ST ZIP Code Fax: ______________

E-Mail: ______________________________

INSURANCE INFORMATION

Subscriber: ______________________________

Last First MI Preferred Title

Subscriber Date of Birth: ______________ Subscriber SSN / ID #: ______________

Subscriber Employer: ______________________________

Patient Relationship to Subscriber: ☐Self ☐Spouse ☐Child ☐Other

Primary Insurance Carrier: ______________________________

Group/Policy No.: ______________ ID No.: ______________

Address: ______________________________ Tel: ______________

______________________________ Toll-free: ______________

______________________________ Fax: ______________

City ST ZIP Code

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Smile Questionnaire

Let us help you have your best smile!

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Tucson, AZ 85712

Patient Name: ______________________________
First MI Last

Please take a few minutes to answer the following questions so that we can help you have the smile you have always wanted.

- Are you able to chew well? ☐ Yes ☐ No
- Are you able to speak well? ☐ Yes ☐ No
- Do you like the shape of your teeth? ☐ Yes ☐ No
- Are your teeth…
  - Chipped? ☐ Yes ☐ No
  - Missing? ☐ Yes ☐ No
  - Crowded? ☐ Yes ☐ No
  - Worn? ☐ Yes ☐ No
  - Spaced Apart? ☐ Yes ☐ No
- Do your gums bleed or hurt? ☐ Yes ☐ No
- Have you ever had gum disease? ☐ Yes ☐ No
- Do you have a gummy smile? ☐ Yes ☐ No
- Do you notice yourself clenching or grinding? ☐ Yes ☐ No
- Do you bite your lips or cheeks? ☐ Yes ☐ No
- Does your jaw feel tired or sore? ☐ Yes ☐ No
- Do you have dry mouth? ☐ Yes ☐ No
- Do you frequently get cold sores, blisters? ☐ Yes ☐ No

What do you like the best about your smile?

Do you like the color of your teeth? ☐ Yes ☐ No

☞Continue on Back☞

What do you like the least about your smile?

Circle any of the following that you would like more information about.

Crowded or Crooked Teeth	Discolored Teeth or Crowns	Gummy Smile
Missing Teeth	Reshaping Teeth	Straightening Teeth
Spaces	Tooth Shape or Size	Under or Over Bite
Teeth Whitening	Other____	

Did your last dentist ever review long term goals for your dental health? ☐ Yes ☐ No

Please share with us why you left your last dentist.

What's most important to you about your dental experience with us?

Have you ever experienced a dental emergency? ☐ Yes ☐ No

Please share any additional comments or suggestions.

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Patient Name: ______________________________
First MI Last

Medical History

Who is your primary physician? Physician's Name: ______________________________ Tel: ______________________

☐Y ☐N Any serious illnesses currently?

☐Y ☐N Any hospitalization in the past 3 years? If yes, why? __________________

☐Y ☐N Any upcoming surgeries? Date: ___.___.____

☐Y ☐N Use tobacco in any form? If Yes, Type: ______________________________

☐Y ☐N Is pre-medication required before dental visits due to heart condition or artificial joint?

For Female Patients: Currently Nursing? ☐Y ☐N Currently Pregnant? ☐Y ☐N Due Date: ___.___.____

All Patients: Do you have, or have you ever had any of the following? (Check ALL that apply) ☐None

☐Acid Reflux	☐Bulimia	☐Hearing Problem	☐Psychiatric Treatment
☐ADHD	☐Cancer/Malignancy (↳Type:_______________)	☐Heart Attack	☐Radiation/Chemo (Year___)
☐AIDS/HIV	☐General Palsy	☐Heart Disease	☐Respiratory Disease
☐Anemia	☐Chemical Dependency	☐Heart Murmur	☐Rheumatic Fever
☐Anorexia	☐Chicken Pox	☐Hepatitis	☐Sinus Problems
☐Anxiety	☐Convulsions	☐High Blood Pressure	☐Stroke
☐Artificial Heart Valve	☐Depression	☐Kidney Disease	☐Thyroid Condition
☐Artificial Joints (Year___)	☐Diabetes (Last A1c____)	☐Liver Problems	☐Tuberculosis
☐Arthritis	☐Dizziness/Fainting	☐Mitral Valve Prolapse	☐Ulcers
☐Asthma	☐Epilepsy/Seizures	☐Mononucleosis	☐Venereal Disease
☐Autism/Asperger's	☐Frequent Ear Infections	☐Pacemaker	
☐Bleeding Disorder	☐Frequent Headaches	☐Other - Please list: ______________________________	

All Patients: Are you ALLERGIC to or have you ever had any reaction to the following? (Check all that apply) ☐None

☐Aspirin	☐Codeine	☐Lactose Intolerance	☐Sleeping Pills
☐Anesthetic - Local	☐Dairy	☐Metal Sensitivity	☐Sulfa Drugs
☐Barbiturates	☐Latex	☐Nitrous Oxide Sedation	☐Penicillin/Other Antibiotics

☐Other - Please list: ____

☞Continue on Back☞

Medication Information

Have you ever taken **bone loss prevention drugs** such Fosamax, Bonive, Bisphosphonate or other similar drug? ☐ **Y** ☐ **N**

When was the last time taken? ________________ Medication Name:_______________________

All Patients: Are you currently taking any of the following? (Check all that apply) ☐ None

☐ Antibiotics/Sulfa Drugs	☐ Antihistamines/Allergy Pills	☐ Daily Aspirin	☐ Blood Pressure Medication
☐ Blood Thinners	☐ Cancer/Chemo Medication	☐ Cortisone/Steroids	☐ Heart Medication/Digitalis
☐ Insulin	☐ Nitroglycerin	☐ Oral Contraceptives	☐ Osteoporosis Medication
☐ Other Diabetic Medications	☐ Recreational Drugs	☐ Thyroid Medication	☐ Tranqulizers

Please list all your current medication ⇩

Drug Name	Dosage	Reason Prescribed

Is there anything important about your medical condition we have not asked? ☐ Y ☐ N If yes, please describe below:

I understand above information necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient/Guardian Signature: ________________________________ **Date:**________________________

Dentist Signature:____ **Date:** ________________________

Consent for Treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnoses of patient's dental needs.

2. Upon such diagnoses, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication is necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor or designated staff to disclose of any oral, written or electronic health records that are individually identifiable as mine for the purpose of caring out my treatment, payment, and healthcare operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. If I have dental insurance I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Prime Dental.

6. I agreed to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Patient/Guardian Signature:__________________________________ **Date:**_________________

Relationship to the patient:________________________

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Financial Guidelines

We are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.

Insurance

We accept all major dental insurance payments, however we may not be an in network provider for your plan. If we are not an in network provider, review your plan details, as in many cases insurance reimbursement is very similar.

- **No estimate is a guarantee of payment.** Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, you would be responsible for the difference.

- **Minors must be accompanied by a parent or legal guardian**. If the parents are separated or divorced, the person accompanying the minor will be responsible for copayment at the time of service.

Payments

- **Patient portion or patient co-pay is due at the time services are rendered** - unless prior financial arrangements have been made.

- **Payment Information:**
  - All major credit cards are accepted (Visa, MasterCard, Discover)
  - Various financing options with CareCredit®

Short Cancelled/ Missed Appointments

- **Please give 24 hours notice** if you are unable to keep your reserved time. Unless an emergency occurs, we expect to run on time for your appointments, and we appreciate the same courtesy from you.

- **Short canceled or missed appointments** will be charged $25 per scheduled hour.

By signing below I acknowledge I have read and understand the guidelines above.

Signature:___________________________________ Date:____________________

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Communication Consent

- I give permission for the following communications to be used by Craycroft Prime Dental **(please check all that apply)**:

☐ Cell Phone ☐ Text Message ☐ Home Phone ☐ E-Mail ☐ Work

- I am granting permission for Craycroft Prime Dental to disclose their identity to anyone who may answer my home, work or cell phone.
- I am granting permission for Craycroft Prime Dental to leave a message with any person who may answer my phone or on my voicemail of the following numbers **(please check all that apply)**:

☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ None-Please just ask for a call back

☐ Other (Please explain) ____

Print Patient Name:______________________ **Print Guardian Name:**______________________

Patient/Guardian Signature: ____________________________________ **Date:** ________________

Relationship To Patient: ☐ Patient Self ☐ Parent ☐ Guardian ☐ Other

Authorization For Release Of Information

I would like to give permission for the following person(s) to have access to personal information including but not limited to appointments, treatment, and billing of myself:

Name of the person(s): ______________________________
Relationship to patient: ☐ Spouse ☐ Parent ☐ Guardian ☐ Other ______________________________

Acknowledgement Of Privacy Practices

Updated 2021

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Print Patient Name:______________________ **Print Guardian Name:**______________________

Patient/Guardian Signature: ____________________________________ **Date:** ________________

Relationship To Patient: ☐ Patient Self ☐ Parent ☐ Guardian ☐ Other

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PATIENT CONSENT- PAYMENT AUTHORIZATION – SIGNATURE ON FILE

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status of if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

I hereby authorize payment directly to **Prime Dental** of the dental benefits otherwise payable to me.

I hereby authorize **Prime Dental** to release any information concerning my health or dental care, advice, treatment or supplies provided. This information is to be used administering dental claims and/or discussing treatment options with other dental professionals.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Signature: ______________________________ Date: ____________________

Multimedia Publicity Release

I hereby grant Prime Dental (hereinafter, "Company") permission to use, reproduce, distribute, publicly perform and display, in any form now known or later developed, the Materials specified in this release throughout the world, for the purpose of advertising and promoting Company's business.

This permission and release are for the following Materials:

- Name (Only First name and first letter of last name; ie. Susie J.)
- Visual likeness (on photographs, video, film, website, etc.)
- Photographs
- Film, videotape or other audio and audiovisual materials
- Written online review

I release "Company", its agents, employees, owners, investors, licensees and assigns from any and all claims I may have now or in the future for invasion of privacy, right of publicity, copyright infringement, defamation or any other cause of action arising out of the use, reproduction, adaptation, distribution, broadcast, performance or display of the Works. By making this release, I do NOT consent to the release of my Private Health Information.

I waive any right to inspect or approve any Works that may be created containing the Materials. I understand and agree that "Company" is and shall be the exclusive owner of all right, title, and interest, including copyright, in the Works, and any advertising or promotional materials containing the Material released hereunder.

I am of full legal age and have read this release. I am fully familiar with its contents, and hereby agree to the terms hereof as of the date indicated below:

Printed Name: ________________________

Signature: ____________________________

Date: ________________________________