Prime DENTAL

PrimeDentalaz.com
520-886-2822
4850 E Broadway Blvd, Tucson, AZ 85711

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More about us!

PATIENT INFORMATION

- Date: _____ ◯New Patient ◯Update
- Name: _____ (First / Middle / Last / Preferred Title)
- Your Biological Sex ◯Male ◯Female
- If the patient is a **child**, please provide the **parent/guardian name(s):** _____
- Date of Birth: _____
- SSN: _____
- Address: _____ (Address line 1)
  _____ (Address line 2)
  _____ (City / State / Zipcode)
- Phone Numbers
  - Mobile: _____
  - Work: _____
  - Other: _____
- E-Mail: _____
- How did you hear about Prime Dental?
  ◯Google/Search engine ◯Instagram/Facebook ◯Friend/Family ◯Other
  Referred by: _____

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person

_____ (Name / Relationship) Contact: _____

EMPLOYMENT INFORMATION

- Employer: _____
- Occupation: _____
- Address: _____ (Address line 1)
  _____ (Address line 2)
  _____ (City / State / Zipcode)
- Work contact number _____
- E-Mail: _____

INSURANCE INFORMATION

- Subscriber: _____ (First / Middle / Last / Preferred Title)
- Subscriber Date of Birth: _____
- Subscriber SSN: _____
- Subscriber Employer: _____
- Patient relationship to subscriber: ◯Self ◯Spouse ◯Child ◯Other
- **Primary Insurance Carrier:** _____
- Group/Policy No.: _____
- ID No.: _____
- Address: _____ (Address line 1)
  _____ (Address line 2)
  _____ (City / State / Zipcode)
- Tel: _____
- Toll-Free: _____
- Fax: _____

Please continue to the next page

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Smile Questionnaire

Let us help you have your best smile!

- Name: _____
  First Middle Last Preferred Title

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
  - Spaced Apart? ◯Yes ◯No
  - Worn? ◯Yes ◯No
  - Crowded? ◯Yes ◯No
  - Missing? ◯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
- Do you like the color of your teeth? ◯Yes ◯No

What do you like the best about your smile?

We want to hear more about your smile! Please 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
- Missing Teeth
- Discolored Teeth or Crowns
- Teeth Whitening
- Reshaping Teeth
- Gummy Smile
- Spaces
- Other_____
- Straightening Teeth
- Under or Over Bite
- Tooth Shape or Size

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

Please share with us why you left last dentist

What's the 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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Medical History

- Name: _____
  First Middle Last Preferred Title
- Who is your Primary physician? Physician's Name: _____ Tel: _____

○Yes ○No Any serious illnesses currently?

○Yes ○No Any hospitalization in the past 3 years? if yes, why?_____

○Yes ○No Any upcoming surgeries? Date: _____._____._____

○Yes ○No Use tobacco in any form? If yes, Type: _____

○Yes ○No Is pre-medication required before dental visits due to a heart condition or artificial joint?

For Female Patients: Currently Nursing? ○Yes ○No Currently Pregnant? ○Yes ○No If yes, Due Date: ____.____.____

Do you have, or have you ever had, any of the following? (Check ALL that apply) ○ None

○ Acid Reflux	○ Chicken Pox	○ Kidney Disease
○ ADHD	○ Convulsions	○ Liver Problems
○ AIDS/HIV	○ Depression	○ Mitral Valve Prolapse
○ Anemia	○ Diabetes(Last A1c_____)	○ Mononucleosis
○ Anorexia	○ Dizziness/Fainting	○ Pacemaker
○ Anxiety	○ Epilepsy/Seizures	○ Psychiatric Treatment
○ Artificial Heart Valve	○ Frequent Ear Infection	○ Radiation/Chemo(Year_____)
○ Artificial Joints (Year_____)	○ Frequent Headaches	○ Respiratory Disease
○ Arthritis	○ General Palsy	○ Rheumatic Fever
○ Asthma	○ Hearing Problem	○ Sinus Problems
○ Autism/Asperger's	○ Heart Attack	○ Stroke
○ Bulimia	○ Heart Disease	○ Thyroid Condition
○ Bleeding Disorder	○ Heart Murmur	○ Tuberculosis
○ Cancer/Malignancy (Type:_____)	○ Hepatitis	○ Ulcers
○ Chemical Dependency	○ High Blood Pressure	○ Venereal Disease

○ Other - Please list all:

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

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

○ Other - Please list all:

Please Continue on Back

Medication Information

Have you ever taken ***BONE LOSS PREVENTION DRUGs*** such Fosamax, Bonive, Bisphosphonate, or other similar drugs? ◯Yes ◯No

When was the last time taken?_____Medication Name: _____

Are you currently taking any of the following? (Check all that apply) ◯ None

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

Please list all your current medication

Drug Name	Dosage	Reason Prescribed

Is there anything important about your medical condition we have not asked for? ◯Yes ◯No
If Yes, please describe below:

I understand above information is necessary to provide me with dental care safely and efficiently. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare 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:** _____.____.____

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Consent for Treatment

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.
2. Upon such diagnoses, I authorize the doctor to perform all recommended treatments mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree that the use of anesthetics, sedatives, and other medication is necessary. I fully understand that using anesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications.
4. I give consent to the doctor or designated staff to disclose any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying 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, that 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 Circle all that apply**):
  - Cell Phone • Text Message • Home Phone • E-Mail • Work
- I am granting permission for 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 Circle all that apply**):
  - Cell Phone • Home Phone • Work Phone • None—Please just ask for a callback
  - 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 _____

Acknowledgment Of Privacy Practices

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 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 healthcare 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 or 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 in 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: _____

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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 the Company's business.

This permission and release are for the following Materials:

• Name (Only First name and the first letter of the last name; i.e. 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 releasing 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 rights, 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 thoroughly familiar with its contents and hereby agree to the terms hereof as of the date indicated below:

Printed Name: _____

Signature: _____

Date: _____