AHWATUKEE
FAMILY DENTAL
Family and Cosmetic Dentistry

4350 E. Ray Road, Bldg 3, Suite 112, Phoenix, AZ | 480-893-7674 | www.AhwatukeeFamilyDental.com

PATIENT INFORMATION

Patient Name: _____ Male: ☐ Female: ☐

Email Address: _____ Preferred Method of Contact: Text ☐ Call ☐ Email ☐

Cell Number: _____ Birth Date: _____ Age: _____ SS#: _____

Home Number: _____ Work Number: _____ Ext.: _____

Home Address: _____
APT/CONDO # CITY/STATE ZIP CODE

Single ☐ Married ☐ Widdowed ☐ Divorced ☐ Separated ☐ Drivers License #: _____

Employer: _____ Occupation: _____

Employer's Address: _____

Whom may we thank for referring you? _____

Previous/Present Dentist: _____ Last Visit Date: _____
(CIRCLE ONE)

SPOUSE INFORMATION

Spouse Information – His/Her Name: _____

Employer: _____ Work #: _____ Ext: _____

Person Responsible For Account: _____ Contact #: _____

Billing Address: _____ Work #: _____ Ext: _____

Relation: _____ SS#: _____

Employer: _____ DL#: _____

INSURANCE COVERAGE

PRIMARY

Dental Coverage: YES ☐ NO ☐ Insurance Co. Name: _____

Insurance Co. Address: _____
SUITE # CITY/STATE ZIP CODE

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

Insured's Name: _____ Relation: _____

Insured Birthdate: _____ Insured's ID#: _____ Insured's Employer: _____

SECONDARY

Dental Coverage: YES ☐ NO ☐ Insurance Co. Name: _____

Insurance Co. Address: _____
SUITE # CITY/STATE ZIP CODE

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

INSURANCE COVERAGE
SECONDARY CONT.

Insured's Name: _____ Relation: _____

Insured Birthdate: _____ Insured's ID#: _____ Insured's Employer: _____

In the event of an emergency, is there someone whom we can contact?

His/Her Name: _____ Relationship: _____

Contact #: _____ Work #: _____

MEDICAL HISTORY

Do you have a personal physician? Yes ☐ No ☐ Physician's Name: _____

Phone #: _____ Date of Last Visit: _____ Are You Currently Under The Care of a Physician? YES NO (CIRCLE ONE)

If so, please explain: _____

Your current health is: ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription/ over-the-counter or herbal supplement drugs? ☐ YES ☐ NO

If so, please list each one: _____

Have you ever taken Fosamax, or any other bisphosphonate? ☐ YES ☐ NO Have you ever taken Phen-fen? ☐ YES ☐ NO

FOR WOMEN: Are you using a prescribed method of birth control? ☐ YES ☐ NO Are you pregnant? ☐ YES ☐ NO

If you are pregnant, how many weeks? _____ Are you nursing? ☐ YES ☐ NO

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

☐ YES ☐ NO Abnormal Bleeding
☐ YES ☐ NO Alcohol / Drug Abuse
☐ YES ☐ NO Anemia
☐ YES ☐ NO Arthritis
☐ YES ☐ NO Artificial Bones/Joints/Valves
☐ YES ☐ NO Asthma
☐ YES ☐ NO Blood Transfusion
☐ YES ☐ NO Cancer/Chemotherapy
☐ YES ☐ NO Colitis
☐ YES ☐ NO Congenital Heart Defect
☐ YES ☐ NO Diabetes
☐ YES ☐ NO Difficulty Breathing
☐ YES ☐ NO Emphysema
☐ YES ☐ NO Epilepsy
☐ YES ☐ NO Fainting Spells
☐ YES ☐ NO Frequent Headaches
☐ YES ☐ NO Glaucoma
☐ YES ☐ NO Hay Fever
☐ YES ☐ NO Heart Attack
☐ YES ☐ NO Heart Murmur
☐ YES ☐ NO Heart Surgery
☐ YES ☐ NO Hemophilia
☐ YES ☐ NO Hepatitis
☐ YES ☐ NO Herpes / Fever Blisters
☐ YES ☐ NO High Blood Pressure
☐ YES ☐ NO HIV+ / AIDS
☐ YES ☐ NO Hospitalized for Any Reason
☐ YES ☐ NO Kidney Problems
☐ YES ☐ NO Liver Disease
☐ YES ☐ NO Low Blood Pressure
☐ YES ☐ NO Mitral Valve Prolapse
☐ YES ☐ NO Pacemaker
☐ YES ☐ NO Psychiatric Problems
☐ YES ☐ NO Radiation Treatment
☐ YES ☐ NO Rheumatic / Scarlet Fever Seizures
☐ YES ☐ NO Shingles
☐ YES ☐ NO Sickle Cell Disease / Traits
☐ YES ☐ NO Sinus Problems
☐ YES ☐ NO Stroke
☐ YES ☐ NO Thyroid Problems
☐ YES ☐ NO Tuberculosis (TB)
☐ YES ☐ NO Ulcers
☐ YES ☐ NO Venereal Disease

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

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ YES ☐ NO Aspirin
☐ YES ☐ NO Codeine
☐ YES ■ NO Dental Anesthetics
☐ YES ☐ NO Erythromycin
☐ YES ☐ NO Jewelry
☐ YES ☐ NO Latex
☐ YES ☐ NO Metals
☐ YES ☐ NO Penicillin
☐ YES ☐ NO Tetracycline

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

DENTAL HISTORY

Please check all that apply:

- ☐ Toothache
- ☐ Broken filling or tooth
- ☐ Clench or grind teeth
- ☐ Food catches
- ☐ Loose teeth
- ☐ Floss breaks easily or hurts
- ☐ Bite or teeth have shifted
- ☐ Often bite cheek
- ☐ Frequent dry mouth
- ☐ Concerned about breath
- ☐ Bad previous dental work
- ☐ Gums bleed
- ☐ Gums tender
- ☐ Growths, Sores
- ☐ Cold Sores, fever blisters
- ☐ Cracked chapped lips
- ☐ Bad taste in mouth
- ☐ Sinus problems
- ☐ Mouth breath – Difficult breathing through nose
- ☐ Dry or strained eyes
- ☐ Shoulder, neck or headaches
- ☐ Clench or grind teeth
- ☐ Jaw joint pain
- ☐ Clicking or popping of jaw
- ☐ Unable to open mouth wide
- ☐ Jaw tires easily
- ☐ Hold things between teeth (pipe, pencil, nails, pins)
- ☐ Bite fingernails
- ☐ Unusual habits with teeth
- ☐ Wore braces
- ☐ Previous gum treatment
- ☐ Previous bite treatment

Sensitivity to:

- ☐ Cold
- ☐ Hot
- ☐ Sweets
- ☐ Chewing

Is there anything that bothers you (even just a little) about the appearance of your teeth or smile? _____

_____

Please rate 1–10 how anxious you are about dental treatment (1 = totally relaxed) _____

Have you ever had a bad experience at the dentist? (Treatment? Staff? Billing?) _____

_____

How did you hear about our office? _____

Do you require antibiotics before dental treatment? ☐ YES ☐ NO Are you currently in pain? ☐ YES ☐ NO

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ YES ☐ NO

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ YES ☐ NO

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Would you like whiter teeth? ☐ YES ☐ NO Fresher Breath? ☐ YES ☐ NO

How many times a week do you floss? _____ A day do you brush? _____

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

Do you smoke or use tobacco in any other form? ☐ YES ☐ NO

APPOINTMENT GUIDELINES

We believe in the value of clear communication, as well as mutual understanding and respect prior to treatment rendered. It is our desire to provide high-quality dental care and individual attention for you in a timely manner. Your appointment time has been reserved especially for you and we make every effort to remind patients of their appointment as a courtesy. Therefore, if you break an appointment without 24 hours' notice, we do not have sufficient amount of time to rebook another patient in need of treatment. With this in mind, a $50.00 fee may be subject to the second missed appointment or cancellation less than 24 hours from you scheduled time. This fee must be paid in full prior to any further appointment(s) scheduled.

INITIALS _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.
I authorize the dental staff 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 the time of treatment unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co- payment and deductibles that my insurance does not cover.

Signature Date

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

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

_____

Medical History Update

Date: _____ Comments: _____ Signature: _____

Date: _____ Comments: _____ Signature: _____

Date: _____ Comments: _____ Signature: _____