



602.404.7266
602.494.2389 fax

4611 E. Shea Blvd. Ste. 250
Phoenix, AZ 85028

LifeSmilesDentalCare.com

We would like to get to know you better!

Date _____

Name _____ Male Female

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell phone _____

E-mail Address _____ Date of Birth _____

Occupation _____ Employer _____

Parent or Spouse's Name _____ Their Work Phone _____

Whom may we thank for referring you? _____

Person to Contact in case of emergency _____ Phone _____

Person responsible for dental investment _____

Dependents that are covered under parents Insurance and over the age of 18 we need a copy of Student Status for Insurance purpose.

Student Status: Full Time Total Semester Hr's _____ Part Time Total Semester Hr's _____

For Insurance Purposes:

Name of policy holder _____ Date of Birth _____ Relationship to Patient: _____

SS# _____ Member I.D. _____ Employer _____

Insurance Company _____

Ins. Company Number _____ Group Number _____

HIPPA Compliance Statement

Your health information may be used in our office to conduct scheduling and coordination of care between the doctor, dental assistant, hygienist and business office staff. We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. Your health information may be reviewed during the routine process of certification, licensing, credentialing activities or auditing for quality assurance.

Communication with our patients is an important part of our philosophy. We prefer to communicate with you directly but we may incorporate the use of phone messages, postcards, and letters. We will make every effort to respect your privacy and honor your request for confidentiality. If you have special needs in regards to privacy issues, please put them in writing for the office so that we may address your concerns.

Financial Information:

I have read and truthfully answered the above questions to the best of my knowledge. I authorize the doctor and/or his staff to release all information necessary to secure payment of my benefits from my insurance company.

I understand that fees may vary at the time of service due to the extent of treatment. Fees are estimates only and are not a guarantee of payment by my insurance company. I understand that the payment of this account is my responsibility, regardless of the amount my insurance company reimburses before or after payment in made.

Patient Signature: _____ Date: _____

Dentist/Hygienist Signature: _____ Date: _____



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Patient Name: _____

Medical History Please circle (Y) for "yes" or (N) for "no" for any of the following which may apply to you now or in the past:

- | | |
|--|---|
| Y N Heart attack or Heart Trouble | Y N Ulcers, Reflux, or Heartburn |
| Y N Congenital Heart Disease | Y N Digestive disorders |
| Y N Chest pain with exercise (angina) | Y N Kidney problems |
| Y N High Blood Pressure | Y N Fainting or Blackouts |
| Y N Heart Valve disorder | Y N Headaches or Migraines |
| Y N Pacemaker | Y N Epilepsy or Seizures |
| Y N Implants or Artificial Joint When? _____ | Y N Tumors, Cancer, radiation treatment |
| Y N Anemia or blood disorder | Y N Tuberculosis, lung problems |
| Y N Excessive bleeding | Y N Hepatitis A B C D |
| Y N Diabetes | Y N AIDS or HIV infections |
| Y N Stroke | Y N Psychiatric Disorders |
| Y N Thyroid disease | Y N Use tobacco? How much? _____ |
| Y N Asthma | Y N Drug/Alcohol dependency |

Is there any family history of the following?

- | | |
|----------------------|------------|
| Y N Heart Disease | Y N Stroke |
| Y N Early Term Birth | Y N Cancer |

Are you currently pregnant? _____ If yes when are you expecting: _____

Have you seen a physician or been hospitalized in the last two years (including pregnancy)? Y N

If yes, please explain _____

Physician's name and phone: _____

Have you ever had an allergic reaction to an anesthetic or drug such as penicillin, sedative, aspirin, latex, or metals?

If yes, please explain _____

What prescription or over the counter drugs, medications, vitamins, or herbs are you taking at this time?

Dental History

- | | |
|---|--|
| Y N Are you experiencing any dental discomfort? | Y N Do you ever experience hot/cold/sweet/pressure |
| Y N Is your mouth frequently dry? | Y N Do you grind your teeth? |
| Y N Does your jaw become sore with chewing? | |

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

On a Scale from 0-10, zero being the *least important* and ten being the *most important*, please rate the following:

Dental Anxiety: _____ Optimizing appearance/function: _____

Your Smile: _____ Prevent future problems: _____

Maintain Current Conditions: _____ Problem Driven: _____

Have you ever had any problems associated with previous dental treatment? _____

Patient Signature: _____ Date: _____

Dentist/Hygienist Signature: _____ Date: _____