Please use black ink only.

Modern Dental Care

5610 W. Talavi Blvd., Suite 100 • Glendale, Arizona 85306 • 602-896-8886

Patient Information

Patient Name: _____ ☐ Male ☐ Female Date: _____
Last First MI Preferred Name

Address: _____
Street Apartment # City State Zip Code

Social Security #: _____ Birth Date: _____ ☐ Married ☐ Single ☐ Child ☐ Other

Phone (Home): _____ (Work): _____ Ext: _____ (Mobile): _____

E-mail Address: _____ By phone, best time to call: _____

Employer's Name: _____ Occupation: _____

Insurance Information

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Employer Name: _____ Group #: _____

Insurance Company Name: _____ Insured Member ID #: _____

Responsible Party Information

Name: _____ ☐ Male ☐ Female Relationship to patient: _____
Last First Mi

Social Security #: _____ Birth Date: _____ ☐ Married ☐ Single ☐ Other

Address: _____
Street Apartment # City State Zip Code

Phone (Home): _____ (Work): _____ Ext: _____ (Mobile): _____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, patient name: _____

☐ Office sign ☐ AZ Dental Association ☐ Insurance Book ☐ Other: _____

Do we see any other family members as patients? If so, please list: _____

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment is expected.

☐ Cash ☐ Check ☐ Credit card ☐ Debit card ☐ I wish to discuss the office's payment policy.

Consent for Treatment

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

I agree 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. In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made. Should I fail to meet these financial arrangements, I shall pay any additional collection and legal fees that may become necessary in collection of this account.

_____ Date: _____ Relationship to Patient _____
Signature of patient, parent, or guardian

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Dental History

Reason for your visit today: _____

Date of last dental visit: _____ What was done at your last dental visit? _____

How often do you have dental examinations? _____ How often do you brush your teeth? _____

How often do you floss? _____ Are your teeth sensitive to: ☐ None ☐ Hot ☐ Cold ☐ Biting/Chewing ☐ Sweets

Do you presently have or have you ever had any of the following:

Y	N		Y	N	
☐	☐	Clenching or grinding	☐	☐	Smoke/chew tobacco
☐	☐	Jaw popping or clicking	☐	☐	Had immediate relative experience gum disease
☐	☐	Difficulty opening/closing	☐	☐	Bad dental experience, please explain:
☐	☐	Bleeding gums			
☐	☐	Previous periodontal treatment			_____

- Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely
- Are you happy with the appearance of your teeth? ☐ Yes ☐ No Why? _____

Patient Health Information

Have you ever had any of the following? Please check those that apply:

☐ Allergies—Codeine	☐ Diabetes	☐ High Blood Pressure	☐ Rheumatism
☐ Allergies—Penicillin	☐ Epilepsy	☐ Kidney Disease	☐ Sinus Problems
☐ Allergies—Sulfur	☐ Excessive Bleeding	☐ Latex Allergy	☐ Stomach Problems
☐ Arthritis	☐ Facial Palsy	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joints (hip, knee)	☐ Fainting	☐ Nervous / Anxious	☐ Tuberculosis
☐ Asthma	☐ Heart Disease	☐ Pre-Med c/ Antibiotic	☐ Tumors / Growth
☐ Cancer	☐ Heart Murmur	☐ Radiation / Chemotherapy	☐ Ulcers
☐ Cold Sores / Blisters	☐ Heart Pacemaker	☐ Respiratory Problems	☐ Wheelchair
☐ Deaf	☐ Hepatitis A, B, or C	☐ Rheumatic Fever	

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you currently taking any medications, drugs, or pills? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you aware of having an allergic (or adverse) reaction to any medication or substance? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

_____ _____ Date: _____ Dr. initial _____

Signature of patient, parent or guardian Printed name

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Dental Profile

Patient _____ Date_____

	Yes	No
• Do your gums bleed? Where? _____	☐	☐
• Do you feel you have bad breath?	☐	☐
• Do you wish your teeth were whiter?	☐	☐
• Do you like the way your teeth are shaped?	☐	☐
• Are you pleased with the appearance of your smile?	☐	☐
• Are you interested in cosmetic dentistry?	☐	☐
• Are you interested in orthodontics or Invisalign?	☐	☐

- On a scale from 1 – 10, how important is it for you to keep your teeth for a lifetime? (10 indicating very important) _____

- On a scale from 1 – 10, how would you rate your apprehension with dental visits? (10 indicating very nervous) _____

Why did you leave your previous dental office?

_____

_____