Patient Name

Last Name *First Name* *Initial*

Patient Email

DENTAL HISTORY

Patient Birthdate

Welcome! Please complete both sides of this dental/medical history form so that we may provide you with the best possible dental care.
All information is completely confidential. This office does not use this information to discriminate.

Patient Information

Address _____ City _____ State_____ Zip _____
Home Phone _____ Cell Phone_____ Soc. Sec. # _____
Sex ❒ M ❒ F Employer/Occupation _____ ❒ Single ❒ Married ❒ Widowed ❒ Divorced
Notify in case of emergency_____ Relationship_____
Home Phone _____ Cell Phone _____ Email _____
How did you hear about our office? ❒ Internet ❒ Insurance ❒ Drive by ❒ Other:_____
Do you have any family members that are patients at our office? Name:_____

Is the patient covered by **insurance**? ❒ Yes ❒ No
Subscriber Name _____ Relation to Patient _____ Birthdate _____
Insurance Company _____ Phone #_____
Subscriber # _____ Employer _____ Group #_____
Is the patient covered by **additional/secondary** insurance? ❒ Yes ❒ No
Subscriber Name _____ Relation to Patient _____ Birthdate _____
Insurance Company _____ Phone #_____
Subscriber # _____ Employer _____ Group #_____

Dental Information

What is the reason for your visit today? _____
Date of last dental cleaning? _____ Date of last full mouth x-rays? _____
Previous Dentist's Name _____Telephone _____
Address _____ City _____ State_____ Zip _____
How do you feel about the appearance of your teeth? _____
Are you currently experiencing dental pain or discomfort? ❒ Yes ❒ No
How often do you brush your teeth? _____ How often do you floss? _____
Have you ever used or are you currently using topical fluoride? ❒ Yes ❒ No
Do you feel nervous about having dental treatment? ❒ Yes ❒ No
Do you use tobacco (smoking, snuff, chew, bidis)? ❒ Yes ❒ No
If so, how interested are you in stopping? *Circle one* VERY / SOMEWHAT / NOT INTERESTED
Do you drink alcoholic beverages? ❒ Yes ❒ No If yes, how much do you typically drink in a week?_____
Have you ever been told to take a **premedication** or **antibiotics** prior to dental treatment? ❒ Yes ❒ No
Have you ever experienced an adverse reaction during or in conjunction with a dental procedure? ❒ Yes ❒ No
If yes, please describe:_____
Is there any other information about your dental health that you would like us to know? ❒ Yes ❒ No
If yes, please describe:_____

Check (✓) yes or no whether you have had any of the following:

❒ Y ❒ N Sensitivity to hot or cold	❒ Y ❒ N Sores or growths in mouth	❒ Y ❒ N Biting lips/cheeks regularly
❒ Y ❒ N Sensitivity when chewing	❒ Y ❒ N Bleeding/painful gums	❒ Y ❒ N Mouth Breathe
❒ Y ❒ N Noticed any mouth odors	❒ Y ❒ N Grinding or clenching teeth	❒ Y ❒ N Smoke/chew tobacco
❒ Y ❒ N Orthodontic treatment	❒ Y ❒ N Oral surgery	❒ Y ❒ N Mouth guard appliance
❒ Y ❒ N Clicking/popping of the jaw	❒ Y ❒ N Pain (jaw, ear, side of face)	❒ Y ❒ N Difficulty opening the mouth
❒ Y ❒ N Difficulty closing the mouth	❒ Y ❒ N Headaches	❒ Y ❒ N Sensitivity to sweets

Patient Name

Last Name *First Name* *Initial*

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MEDICAL HISTORY

Patient Birthdate

Are you currently under the care of a physician? ❒ Yes ❒ No
Physician's Name _____ Phone # _____
Physician's Office _____ Fax #_____
Have there been any changes in your general health within the past two years? ❒ Yes ❒ No
If yes, please describe:_____
Have you had a serious illness, operation or been hospitalized in the past 5 years? ❒ Yes ❒ No
If yes, please describe:_____
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ❒ Yes ❒ No Date:_____
Have you ever had any heart complications or a heart condition? (Congenital heart disease, congestive heart failure/defects, angina, arteriosclerosis, damaged heart valves, infective endocarditis, heart surgery, etc.) ❒ Yes ❒ No
If yes, please describe:_____
Have you ever taken or are you scheduled to begin taking an antiresorptive agent/bone loss prevention drug (like Fosamax, Actonel, Boniva, Reclast, Prolia or other similar drugs) for osteoporosis or Paget's disease? ❒ Yes ❒ No
Have you ever taken prescription medications for weight loss (diet pills)? ❒ Yes ❒ No
If yes, did you take any of the following? (Check if yes) ❒ Fen-Phen ❒ Pondimen ❒ Redux ❒ Other:_____
If yes to any of the above, did you have a medical exam for heart issues? ❒ Yes ❒ No
Are you taking or have you recently taken any prescription or over the counter medicine(s)? ❒ Yes ❒ No (If yes, see page 3)

WOMEN ONLY Are you: Pregnant? ❒ Yes ❒ No If so, number of weeks: _____
Taking birth control pills or hormonal replacement? ❒ Yes ❒ No Nursing? ❒ Yes ❒ No

Check (✓) yes or no whether you are **allergic** or have had a reaction to any of the following:

❒ Y ❒ N Local anesthetics
❒ Y ❒ N Aspirin
❒ Y ❒ N Penicillin or other antibiotics
❒ Y ❒ N Sulfa drugs
❒ Y ❒ N Metals
❒ Y ❒ N Latex (rubber)
❒ Y ❒ N Codeine or other narcotics
❒ Y ❒ N Other: _____

Check (✓) yes or no whether you have or have not had any of the following diseases or problems:

❒ Y ❒ N AIDS or HIV infection
❒ Y ❒ N Anaphylaxis
❒ Y ❒ N Anemia
❒ Y ❒ N Arthritis, Rheumatism
❒ Y ❒ N Artificial heart valve
❒ Y ❒ N Asthma
❒ Y ❒ N Atopic (allergy prone)
❒ Y ❒ N Autoimmune disease
❒ Y ❒ N Blood disease/ transfusion
❒ Y ❒ N Cancer/Chemotherapy/ Radiation treatment
❒ Y ❒ N Cardiovascular disease
❒ Y ❒ N Chemical dependency
❒ Y ❒ N Circulatory problems
❒ Y ❒ N Cortisone treatments
❒ Y ❒ N Chronic pain
❒ Y ❒ N Diabetes Type I or II
❒ Y ❒ N Emphysema
❒ Y ❒ N Fainting spells or seizures
❒ Y ❒ N G.E Reflux/persistent heartburn
❒ Y ❒ N Glaucoma
❒ Y ❒ N Hepatitis or liver disease
❒ Y ❒ N Hemophilia
❒ Y ❒ N Heart attack
❒ Y ❒ N Heart problems or murmur
❒ Y ❒ N Herpes
❒ Y ❒ N High or low blood pressure
❒ Y ❒ N Kidney problems/ disease
❒ Y ❒ N Mental health/neurological disorders
❒ Y ❒ N Mitral valve prolapse
❒ Y ❒ N Neurological disorders
❒ Y ❒ N Osteoporosis
❒ Y ❒ N Pacemaker/heart surgery
❒ Y ❒ N Rheumatic fever
❒ Y ❒ N Respiratory disease
❒ Y ❒ N Stroke
❒ Y ❒ N Shingles
❒ Y ❒ N Shortness of breath
❒ Y ❒ N Surgical implant/ joint replace.
❒ Y ❒ N Swelling of feet or ankles
❒ Y ❒ N Severe headaches/migraines
❒ Y ❒ N Severe or rapid weight loss
❒ Y ❒ N Sexually transmitted disease
❒ Y ❒ N Sinus trouble
❒ Y ❒ N Thyroid disease or malfunction
❒ Y ❒ N Tobacco habit
❒ Y ❒ N Tuberculosis
❒ Y ❒ N Ulcer/colitis

Do you have any disease, condition, or problem not listed above that you think I should know about? ❒ Yes ❒ No
Please explain:_____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian:_____ Date:_____
Signature of Dentist:_____ Date:_____

Patient Name

Last Name *First Name* *Initial*

Patient Email

MEDICAL HISTORY CONT.

Patient Birthdate

Please list below any **prescription(s)** or **over the counter medicine(s)** you are taking or have recently taken:

Medication Name	**Prescriber**	**Start Date of Medication**

For Completion By The Dentist ONLY

Medical History Update:

Date	**Comments**	**Signature**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

WILDFLOWER DENTAL
PAYMENT POLICY

Thank you for choosing our office for your healthcare needs. Generally, payment is due as services are rendered. We accept debit/credit cards, personal checks, Care Credit and cash for your convenience. Financial arrangements can be made on extensive treatment PRIOR TO the date services are to be rendered. Credit will be extended based on past credit history in our office. The length of the extension will be limited, as we do not have the lending resources of a bank.

REGARDING APPOINTMENTS:
Your appointment time is reserved specifically for you. If you are unable to keep your appointment, we ask that you give 24 hour notice. We have an answering machine if you need to call after hours. However, please call back the next morning to confirm that we received your message.

Failure to give 24 hour notice will result in a broken appointment fee of $25.

REGARDING INSURANCE:
We will accept insurance on assignment, but you must satisfy your deductible and pay the percentage of your responsibility as treatment is rendered. (e.g. If your insurance pays 80% of your care, you will be required to pay 20% on each office visit.) Your estimated portion is due at the time of your visit and you will only be billed if your insurance does not pay the estimated amount. Verification of benefits is required. It is your responsibility to notify our office if your benefits have changed. If we are unable to verify your benefits, you will be responsible for payment in full at the time services are rendered.

We will bill your insurance company as a 3rd-party courtesy to you and absorb costs, within reason, incurred for billing. Your signature below will also serve as assignment of your insurance benefits to our office.

Regardless of insurance status, you are responsible for charges incurred for treatment rendered.

Since by taking your insurance on assignment we have to wait for payment, this courtesy may be withdrawn if circumstances warrant it.

Our office DOES NOT guarantee that your insurance will pay. If your insurance company fails to pay your claim within 60 days, you will be billed directly for any applicable amounts.

Our office WILL NOT enter into a dispute with your insurance company over your claim. This is your responsibility and obligation. Your insurance benefit is a contract between you and your insurance company. However, we will provide whatever support documents and narratives that may be needed to assist you in obtaining your rightful benefits.

REGARDING DIVORCE AND BILLING CHARGES:
This office is not a party to any divorce decrees or legal disputes. We may bill the responsible party as a courtesy. Please understand that our legal right is to bill the party or (or guardian) that presents for treatment.

All accounts turned over to our collections agency will be subject to added financial charges, collection costs, attorney's fees, and any other costs that may be incurred to enforce the collections of any amount outstanding.

I have read and understand the above statements.

_____

Signature (Parent or Guardian, if minor) ***Date***

**If you have any questions concerning our office payment policy, please feel free to ask.*

PRIVACY PRACTICES ACKNOWLEDGEMENT

Privacy Notice Amendment 2020

I have had the opportunity to read the Patient Privacy Notice for this practice. I understand that I may ask for a copy to take with me at any time, and that an appointed person is available to answer any questions that I may have now, or in the future, regarding the use of my Personal Health Information.

_____ _____

Patient Signature Date

_____ _____

Practice Witness Date

Wildflower Dental

18818 N. 99th Ave., Sun City, AZ 85373
Phone: (623) 815-0512 ○ Fax: (623) 815-0578