Scottsdale Dental Excellence
Jeffrey D. Clark, DDS, FAGD
8765 E. Bell Road, Suite 201, Scottsdale, AZ 85260
480.585.1853 / info@scottsdaledentalexcellence.com
ScottsdaleDentalExcellence.com

# New Patient Forms

Welcome, and thank you for choosing Scottsdale Dental Excellence. For your convenience, the forms contained within this document should be completed prior to your first office visit. Simply print it out, fill it out as completely as you can, and bring it with you to the office on the day of your appointment. Having these forms completed upon arrival will greatly expedite your time spent in the office.

If you have questions, we are more than happy to assist you. We look forward to serving and caring for your oral health needs for years to come!

# PATIENT REGISTRATION

**PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION**

IF THIS APPOINTMENT IS FOR YOU START HERE

## 1

| | | | |
|---|---|---|---|
| DATE | | | |
| LAST NAME | FIRST | | M.I. |
| PREFERS TO BE CALLED BY | | | |
| ADDRESS | | | |
| CITY | | STATE | ZIP |
| HOME PHONE NO. | | FAX | |
| CELL | | EMAIL | |
| BIRTHDATE | AGE | MALE | FEMALE |
| MARRIED | SINGLE | DIVORCED | WIDOWED |
| SOCIAL SECURITY NO. | | | |

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

| | | | |
|---|---|---|---|
| DATE | | | |
| LAST NAME | FIRST | | M.I. |
| ADDRESS | | | |
| CITY | | STATE | ZIP |
| HOME PHONE NO. | | | |
| BIRTHDATE | AGE | MALE | FEMALE |
| SCHOOL | | | GRADE |
| SOCIAL SECURITY NO. | | | |

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

## 2 DENTAL INSURANCE

| PRIMARY CARRIER | |
|---|---|
| INSURANCE COMPANY | |
| GROUP NO. | |
| EMPLOYER NAME | |
| INSURED'S NAME | |
| DATE OF BIRTH | RELATIONSHIP TO PATIENT |
| INSURED'S I.D. NO. | |
| INSURED'S SOCIAL SECURITY NO. | |

| SECONDARY CARRIER | |
|---|---|
| INSURANCE COMPANY | |
| GROUP NO. | |
| EMPLOYER NAME | |
| INSURED'S NAME | |
| DATE OF BIRTH | RELATIONSHIP TO PATIENT |
| INSURED'S I.D. NO. | |
| INSURED'S SOCIAL SECURITY NO. | |

## 3 GETTING TO KNOW YOU

| | | |
|---|---|---|
| **IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?** | | |
| NAME: | RELATIONSHIP: | |
| **YOU WERE REFERRED TO US BY** | | |
| **YOUR FORMER ADDRESS** | | |
| CITY | STATE | ZIP |
| **PERSON TO CONTACT FOR EMERGENCY** | | |
| PHONE NUMBER | | |
| ADDRESS | | |
| CITY | STATE | ZIP |
| **CLOSEST RELATIVE NOT LIVING WITH YOU** | | |
| PHONE NUMBER | | |
| ADDRESS | | |
| CITY | STATE | ZIP |

## 4 ACCOUNT INFORMATION

| PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT | |
|---|---|
| NAME | |
| RELATIONSHIP TO PATIENT | SOCIAL SECURITY NO. |
| ADDRESS | |
| CITY | STATE ZIP |
| PHONE NO. | |

| YOU | |
|---|---|
| NAME | |
| OCCUPATION | |
| EMPLOYER'S NAME | |
| ADDRESS | CITY |
| PHONE NO. | FAX NO. |

| YOUR SPOUSE | |
|---|---|
| NAME | |
| OCCUPATION | |
| EMPLOYER'S NAME | |
| ADDRESS | CITY |
| PHONE NO. | FAX NO. |

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# Consent for Treatment

1. 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 of (name of patient): _____'s dental needs.
2. 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.
3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctors or designated staff's use and disclosure of any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment, and health care 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. 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% monthly late charge (18% APR) may be added to my account. If required, I also understand that a check of my credit history may be made.
6. I understand that when I schedule an appointment, the doctor is reserving that time for my treatment. Since it is not the policy of this practice to double book patients, a 48-hour notice is required to reschedule or cancel any appointment, or I will be charged an $85 per hour fee.

Patient's Signature: _____ Date: _____

Parent/Responsible Party Signature: _____

Relationship: _____

Revised 1/2019

| **Patient Name** | **DENTAL HISTORY** |
|---|---|
| **Patient Account No.** | **Medical Alert** |

*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.**

What is the reason for your visit today? _____

_____

Date of Last Dental Visit? _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____ Telephone _____

Address _____ State _____ Zip _____

How often do you have dental examinations? _____

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

What other dental aids do you use (Interplak, toothpick, etc.)? _____

Do you have any dental problems now? ☐ Yes ☐ No

If yes, please describe: _____

**Are any of your teeth sensitive to:**

| | | |
|---|---|---|
| Hot or cold? | ☐ Yes | ☐ No |
| Sweets? | ☐ Yes | ☐ No |
| Biting or chewing? | ☐ Yes | ☐ No |
| Have you noticed any mouth odors or bad taste? | ☐ Yes | ☐ No |
| Do you frequently get cold sores, blisters or any other oral lesions? | ☐ Yes | ☐ No |
| Do your gums bleed or hurt? | ☐ Yes | ☐ No |
| Have your parents experienced gum disease or tooth loss? | ☐ Yes | ☐ No |
| Have you noticed any loose teeth or change in your bite? | ☐ Yes | ☐ No |
| Does food tend to become caught in between your teeth? | ☐ Yes | ☐ No |

If yes, where? _____

**Do you:**

| | | |
|---|---|---|
| Clench or grind your teeth while awake or asleep? | ☐ Yes | ☐ No |
| Bite your lips or cheeks regularly? | ☐ Yes | ☐ No |
| Hold foreign objects with your teeth (pencils, pipe, pins, nails, fingernails)? | ☐ Yes | ☐ No |
| Mouth breathe while awake or asleep? | ☐ Yes | ☐ No |
| Have tired jaws, especially in the morning? | ☐ Yes | ☐ No |
| Snore or have any other sleeping disorders? | ☐ Yes | ☐ No |
| Smoke/chew tobacco or use other tobacco products? | ☐ Yes | ☐ No |

**Have you ever had:**

| | | |
|---|---|---|
| Orthodontic treatment? | ☐ Yes | ☐ No |
| Oral surgery? | ☐ Yes | ☐ No |
| Periodontal treatment? | ☐ Yes | ☐ No |
| Your teeth ground or the bite adjusted? | ☐ Yes | ☐ No |
| A bite plate or mouth guard? | ☐ Yes | ☐ No |
| A serious injury to the mouth or head? | ☐ Yes | ☐ No |

If yes, please describe, including cause _____

**Have you experienced:**

| | | |
|---|---|---|
| Clicking or popping of the jaw? | ☐ Yes | ☐ No |
| Pain (joint, ear, side of face)? | ☐ Yes | ☐ No |
| Difficulty in opening or closing the mouth? | ☐ Yes | ☐ No |
| Difficulty in chewing on either side of the mouth? | ☐ Yes | ☐ No |
| Headaches, neck aches or shoulder aches? | ☐ Yes | ☐ No |
| Sore muscles (neck, shoulders)? | ☐ Yes | ☐ No |
| Are you satisfied with your teeth's appearance? | ☐ Yes | ☐ No |
| Would you like to keep all of your teeth all of your life? | ☐ Yes | ☐ No |
| Do you feel nervous about having dental treatment? | ☐ Yes | ☐ No |

If so, what is your biggest concern? _____

| | | |
|---|---|---|
| Have you ever had an upsetting dental experience? | ☐ Yes | ☐ No |

If yes, please describe _____

Have you ever been told to take a pre-medication prior to dental treatment? ☐ Yes ☐ No

**Is there anything else about having dental treatment that you would like us to know?** ☐ Yes ☐ No

If yes, please describe _____

| Patient Name | MEDICAL HISTORY |
|---|---|
| Patient Account No. | Medical Alert |

1. Physician's Name _____ Phone ( ) _____
   Have you had any medical care within the past two years? ☐ Yes ☐ No
   Describe _____
2. Have you taken any medication or drugs during the past two years? ☐ Yes ☐ No
3. Are you currently taking an medication, drugs, pills or herbal remedies, including regular dosages of aspirin? ☐ Yes ☐ No
4. 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
5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? ☐ Yes ☐ No
6. Are you aware of having an allergic (or adverse) reaction to any substance or medication? ☐ Yes ☐ No
   If yes, please specify _____
7. Have you been a patient in the hospital during the past five years? ☐ Yes ☐ No
8. Indicate which of the following you have had, or have at present. Check "Yes" or "No" to each item.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Heart (Surgery, Disease, Attack) | ☐ Yes | ☐ No | Kidney Trouble | ☐ Yes | ☐ No | Venereal Disease | ☐ Yes | ☐ No |
| Chest Pain | ☐ Yes | ☐ No | Ulcers | ☐ Yes | ☐ No | AIDS/HIV Positive | ☐ Yes | ☐ No |
| Congenital Heart Disease | ☐ Yes | ☐ No | Diabetes | ☐ Yes | ☐ No | Cold Sores/Fever Blisters | ☐ Yes | ☐ No |
| Heart Murmur | ☐ Yes | ☐ No | Thyroid Problems | ☐ Yes | ☐ No | Blood Transfusion | ☐ Yes | ☐ No |
| High/Low Blood Pressure | ☐ Yes | ☐ No | Glaucoma | ☐ Yes | ☐ No | Hemophilia | ☐ Yes | ☐ No |
| Mitral Valve Prolapse | ☐ Yes | ☐ No | Contact Lenses | ☐ Yes | ☐ No | Sickle Cell Disease | ☐ Yes | ☐ No |
| Artificial Heart Valve/ Pacemaker | ☐ Yes | ☐ No | Emphysema | ☐ Yes | ☐ No | Bruise Easily | ☐ Yes | ☐ No |
| Rheumatic Fever | ☐ Yes | ☐ No | Chronic Cough | ☐ Yes | ☐ No | Liver Disease/Yellow Jaundice | ☐ Yes | ☐ No |
| Arthritis/Rheumatism | ☐ Yes | ☐ No | Tuberculosis | ☐ Yes | ☐ No | Neurological Disorders | ☐ Yes | ☐ No |
| Cortisone Medicine | ☐ Yes | ☐ No | Asthma | ☐ Yes | ☐ No | Epilepsy or Seizures | ☐ Yes | ☐ No |
| Swollen Ankles | ☐ Yes | ☐ No | Hay Fever/Allergy/Hives | ☐ Yes | ☐ No | Fainting or Dizzy Spells | ☐ Yes | ☐ No |
| Stroke | ☐ Yes | ☐ No | Latex Sensitivity | ☐ Yes | ☐ No | Nervous/Anxious | ☐ Yes | ☐ No |
| Diet (Special/Restricted) | ☐ Yes | ☐ No | Sinus Trouble | ☐ Yes | ☐ No | Psychiatric/Psychological Care | ☐ Yes | ☐ No |
| Artificial Joints (Hip, Knee, etc.) | ☐ Yes | ☐ No | Radiation Therapy | ☐ Yes | ☐ No | | | |
| | | | Chemotherapy | ☐ Yes | ☐ No | | | |
| | | | Tumors | ☐ Yes | ☐ No | | | |
| | | | Hepatitus A, B, C | ☐ A | ☐ B | ☐ C | | |

9. Have you lost or gained more than 10 pounds in the last year? ☐ Yes ☐ No
10. Do you have or have you had any disease, condition, or problem not listed? ☐ Yes ☐ No
11. Women: Are you pregnant or think you could be pregnant? ☐ Yes ____ Months ☐ No Nursing? ☐ Yes ☐ No
12. Do you use birth control prescriptions? ☐ Yes ☐ No

I understand the above information in necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient / Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____

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# How Did You Hear About Us?

Referring new patients to our office is the highest compliment we can receive. Please take a moment to let us know **ALL** the ways you heard about our office. Put a check next to each source and then **CIRCLE** the main reason you selected this office. Thank you!

_____ **Dentist or specialist** (His/her name): _____
_____ **Friend or family member** (His/her name): _____
_____ **Insurance provider** (Please specify): _____
_____ **Scottsdale Dental Excellence website**
_____ **Google search**
_____ **Other search engine** (Please specify): _____
_____ **Facebook**
_____ **Instagram**
_____ **Twitter**
_____ **YouTube**
_____ **Other social media** (Please specify): _____
_____ **Yelp**
_____ **Google Reviews**
_____ **PatientConnect365**
_____ **Other review site** (Please specify): _____
_____ **Website or online directory** (Please specify): _____
_____ **Drive-by or walk-by**
_____ **Direct mail or flyer**
_____ **Print magazine or newspaper** (Please specify): _____
_____ **Online advertisement**
_____ **Radio or TV advertisement**
_____ **Community event** (Please specify): _____
_____ **School event and/or presentation** (Please specify): _____
_____ **Brochures delivered to your business**
_____ **Other** (Please specify): _____

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# Financial Policy

A. **PRE-PAY FOR TREATMENT IN FULL:** A prepay courtesy of 5% will be deducted for treatment that exceeds $500 of the total patient obligation **if the patient pays in full** at the time of treatment. This courtesy requires that the patient files their own insurance claim, and payment must be made in full by cash or check only.
B. **DENTAL SAVINGS PLAN (DSP) ANNUAL MEMBERSHIP:** An annual membership is paid to the practice of $175 (this fee may change at any time) that will provide savings on dental treatment. The savings range from 15% for diagnosed Treatment to 50% for Hygiene. More information is available from our Front Office Coordinator.
C. **FINANCING:** For those patients requiring extended payments over a period of time, financing options can be arranged (with Care Credit) in our office as a line of credit for up to 12 months interest-free (depending on the amount). There is no pre-payment penalty, and the process can usually be completed within 15 minutes.
D. **FORMS OF PAYMENT:** You may choose to pay your portion in full with the following options (including a combination of): Visa, Mastercard, American Express, Debit Card, Cash, Check, Money Order, or lines of credit (refer to FINANCING). A $35.00 Insufficient Funds fee will be assessed to your account for every returned check.
E. **MISSED APPOINTMENTS:** We require a 48-hour notice when **canceling or rescheduling appointments** (unless and only in the case of a medical emergency). You will be charged $25 for every half hour scheduled with Hygiene and $50 scheduled for Treatment. This fee must be paid in full prior to rescheduling new appointments. For **missed/no show appointments**, the fees are the same as above. We take your oral health seriously and expect our patients to be our partners and commit to their care.
F. **TREATMENT DEPOSITS:** We require a **non-refundable** 25% deposit on all treatment on the patient's estimated portion of over $1000. This amount will remain on the account until treatment is completed, at which time the deposit will be used to credit the patient's balance. See FINANCING for payment options.
G. **INSURANCE:** Our office understands the value of insurance benefits to our patients. We will process and file your insurance as a courtesy at no charge. At the time of service, you are required to pay your **estimated** portion based on the dental insurance information available. Benefits from most plans range between 50%-80% for treatment and up to 100% for diagnostic/preventative. The insurance companies base the amount of benefit on a schedule of fees that are arbitrarily derived by your

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insurance company. For this reason, **we may receive a lower payment from your insurance company than the estimate we have provided to you**. The insurance company is responsible to you and not our office. We will assist in any way we can. However, there are no guarantees, and payment is due by the patient and/or responsible party regardless of the benefits paid by your dental insurance. Once your dental insurance carrier has paid the claim, any difference will be **due upon receipt of the statement**. If, for any reason, we have not received payment by your dental insurance within 60 days after the claim was submitted, the remaining balance will be your responsibility to be paid by you. Any unpaid balance may be subject to a monthly 18% interest charge. IN THE EVENT OF DEFAULT, LEGAL INTEREST ON THE INDEBTEDNESS, COLLECTION FEES, AND RELATED ATTORNEY FEES MAY BE ADDED TO THE DEFAULTED AMOUNT.

***I understand my financial options and obligations as described above, and any questions I had have been answered.***

_____ _____

Signature Date

Revised 1/2019

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# Notice of Privacy Practices and Patient Consent

_____ _____

**PATIENT NAME** **DATE**

**I understand** that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

**I understand** that Jeffrey D. Clark, DDS, PC, may use or disclose my protected health information for treatment, payment, or health care operations—which means for providing health care to me, the patient; handling billing and payment; and taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Jeffrey D. Clark, DDS, PC, has a detailed document called the ***'HIPPA Notice of Privacy Practices.'*** It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

**I understand** that I have the right to read the *'Notice'* before signing this agreement. If I ask, Jeffrey D. Clark, DDS, PC, will provide me with the most current *Notice of Privacy Practices*.

**My signature** below indicates that I have been given a chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Jeffrey D. Clark, DDS, PC, to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Jeffrey D. Clark, DDS, PC, has taken action relying on this consent.

_____ _____

**SIGNATURE** (Patient or Legal Custodian/Authorized Representative) **DATE**

_____ _____

**Relationship to Patient** if signed by another party **DATE**

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You may obtain a copy of our *Notice of Privacy Practices,* including any revisions of our *'Notice'* at any time by contacting:

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8765 East Bell Road, Suite 201
Scottsdale, AZ 85260
(480) 585-1853

Revised 1/2019

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# Informed Consent for CBCT & Authorization Form

**Patient's Name:** _____ authorizes Jeffrey D. Clark, DDS for CBCT Readers, LLC to charge my account the rate of $75.00 (regular rate) **for interpretation** and case report prepared.

A CBCT scan is usually referred to as a cone beam computerized tomography. This is an x-ray technique similar to a medical CT scan. The technique produces images of your body that depicts internal structures in cross sections rather than the overlapping images typically produced by conventional x-ray exams. Conventional x-rays limit your dentist's ability to evaluate anatomical structures in a 2-dimensional view. Your diagnosis and treatment planning can be enhanced by a more complete understanding of complex 3-dimensional anatomy. The relationship of anatomical structures in 3-D is important in assessing your condition as well as treatment planning for various dental procedures, such as root canal therapy, dental implants, sleep apnea, or oral surgery. CBCT scans may be useful in evaluating and potentially diagnosing conditions that cannot be properly seen with conventional x-rays.

CBCT scans, like conventional CT scans, expose you to radiation. However, the dose from a CBCT is up to 80% less than a traditional CT. CBCT scans are NOT recommended for pregnant women.

_____ I am not pregnant _____ I am pregnant _____ I am unsure

I consent to the above treatment after having been advised of the risks, advantages, and disadvantages of CBCT prior to signing this form.

**By signing** below, I give permission and consent to Jeffrey D. Clark, DDS, to take and share images.

Patient or Guardian Printed Name: _____

Patient or Guardian Signature: _____ Date: _____

Revised 1/2019

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# Release of Dental X-Rays

I, _____, herby give permission to Dr. _____ to release any dental records that I have had taken at his/her office to the underlined person. This is a release of dental records only and any other personal information that the doctor may have not be disclosed to anyone without my permission.

Release of dental records to Jeffrey D. Clark, DDS on Date: _____.

Signature of patient: _____.

Please send x-rays to: Jeffrey D. Clark, DDS
8765 E. Bell Rd, Ste 201
Scottsdale, AZ 85260



Revised 1/2019

# SYMPTOM EVALUATION QUESTIONNAIRE

Patient Name: _____

Date of Birth: _____

**Do you have any of the following symptoms:**

| | |
|---|---|
| Facial pain (G50.1) | ☐ Yes ☐ No |
| Jaw pain or discomfort (R68.84) | ☐ Yes ☐ No |
| Neck pain (M54.2) | ☐ Yes ☐ No |
| Headaches (R51) | ☐ Yes ☐ No |
| Migraine headache (G43.109) | ☐ Yes ☐ No |
| Bone loss/osteolysis (M89.58) | ☐ Yes ☐ No |
| Nasal congestion or sinus problems (J32.0) | ☐ Yes ☐ No |
| Muscle pain (masticatory muscle) (M79.11) | ☐ Yes ☐ No |
| Muscle pain (auxiliary muscle, head and neck) (M79.12) | ☐ Yes ☐ No |
| Muscle inflammation (M60.80) | ☐ Yes ☐ No |
| Ringing in the ears – Tinnitus (H93.19) | ☐ Yes ☐ No |
| Ear pain – Otalgia (H92.09) | ☐ Yes ☐ No |
| Facial swelling (R22.0) | ☐ Yes ☐ No |
| Sleep related problems (G47.33) | ☐ Yes ☐ No |

Other symptom(s): _____

_____

_____

_____

**X** _____ _____

Signature of Patient or Legal Guardian | Date