Elegant Dentistry

PATIENT REGISTRATION

Name: _____ SSN #: _____-_____-_____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _(_____) _____-_____

Cell: _(_____) _____-_____ Email: _____

To receive text messages please text "TEXT ME" to elegantdentistryscw@gmail.com from your cell phone

DOB: _____/_____/_____ Sex: F M Single Married Divorce Child

Patient Employed By: _____ Occupation: _____

Business Address: _____

City: _____ State: _____ Zip: _____ Phone: _(_____) _____-_____

Emergency Contact: _____ Phone: _(_____) _____-_____

Whom may we thank for referring you? _____

DENTAL HISTORY

What would you like us to do today? _____

Date of Last Dental Care: _____/_____/_____ Date of Last X-Rays: _____/_____/_____

PLEASE CIRCLE IF YOU HAVE HAD ANY OF THE FOLLOWING:

Bad Breath Bleeding Gums Clicking or Popping Jaw Food collection in between teeth

Hot sensitivity Cold sensitivity Sweet sensitivity Biting sensitivity

Grinding/Clinching Sores or growths in mouth Previous Periodontal Treatment

Have often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

DENTAL INSURANCE

Insured Person: _____ Relation to Patient: _____

Date of Birth: _____/_____/_____ SSN #: _____-_____-_____

Address (if different from above): _____

City: _____ State: _____ Zip: _____ Phone: _(_____) _____-_____

Cell: _(_____) _____-_____ Email: _____

Employed By: _____ Occupation: _____

Insurance Co: _____ Phone: _(_____) _____-_____

Ins Co Address: _____ City: _____ State: _____ Zip: _____

Subscriber ID#: _____ Group #: _____

Elegant Dentistry

MEDICAL HISTORY

Name: _____ DOB: _____/_____/_____
Date of last medical exam: _____/_____/_____
Have you had any serious illnesses or operations? YES NO If YES please describe: _____
_____
Are you currently under a physicians care? YES NO If YES, please describe: _____
_____
Preferred pharmacy _____ major crossroads _____

PLEASE CIRCLE IF YOU CURRENTLY HAVE ANY OF THE FOLLOWING:

Artificial Heart Valves	AIDS/HIV Positive	Psychiatric Care	Dental Phobic
Aspirin _____mg	Cardiac Transplant	Blood Thinners	Liver Disease
High Blood Pressure	High Cholesterol	Tobacco Habit	Pace Maker
Seizures or Fainting	Hard of Hearing	Hemophilia	Pregnant
Congenital Heart Disease	Thyroid Disease	Dementia	Asthma
Previous Infectious Endocarditis	Kidney Disease	Cancer	Stroke

Mitral Valve Prolapse with Regurgitation Hepatitis: A B C MRSA

Bone Replacement Meds - Date: _____ Other: _____

Artificial Joints: _____ Date: _____ Diabetes: Type 1 Type 2

Have you ever had an adverse reaction to a medical or dental procedure? NO YES

If yes, please explain: _____

Is the patient currently taking any medications (INCLUDING OVER THE COUNTER & HEALTH FOOD SUPPLEMENTS?) Please list: _____

_____

Does the patient have any drug allergies? YES NO **If YES, please describe**: _____

_____

AUTHORIZATION

I understand the notice of practices and give my permission to Elegant Dentistry to mail my unsealed postcard to remind me of my appointment.

I consent to treatment, as necessary, to care for the patient named above. I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge and is only for use in my treatment, billing or processing of insurance benefits. I authorize the insurance company to pay the dentist all insurance benefits otherwise payable to me.

I authorize the dentist to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether paid or not by insurance. All patients are required to take full mouth series x-rays or FMX, at their first complete exam appointment and every 3 to 5 years; depending your oral and medical health. Bitewing x-rays are required minimum once a year.

Signature: _____ Date: _____/_____/_____

PAYMENT IN FULL IS DUE AT THE TIME OF TREATMENT

13925 West Meeker Boulevard, Suite 1A · Sun City West, AZ 85375 · Phone: (623)584- 0733 · Fax: (623) 584-1799

Elegant Dentistry

WRITTEN FINANCIAL POLICY FOR PATIENTS WITHOUT DENTAL INSURANCE

Thank you for choosing our office. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal dental care as easy and manageable as possible by offering several payment options.

Payment Options:

You can choose from:

- **Cash, Check**, Debit Card, American Express, Discover, MasterCard, and Visa
- We offer a courtesy accounting adjustment to patients *(without a discount program)* who pay for their treatment with check or cash **AT THE FIRST SCHEDULED APPOINTMENT**.
- We also accept one-half and two equal payments on treatment over $1,000 OAC
- Convenient Monthly Payment Plans from **Care Credit**
    - Allows you to pay over time
    - No annual fees or prepayment penalties

A fee of $57/hour is charged to patients who miss or cancel more than 1 time in a calendar year without 24 hour notice.

If you have any question, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Signature: _____ Date: _____/_____/_____

Patient Name (please print): _____

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