

PATIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

**MEDICAL HISTORY**

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_ Are you under the care of a physician now?  YES  NO

If yes, please explain: \_\_\_\_\_

Have you ever been hospitalized, and if so for what? \_\_\_\_\_

**CIRCLE any of the following conditions you have or have had in the past. PLEASE DRAW A LINE DOWN EACH ROW IF NOTHING APPLIES, TO INDICATE THAT YOU HAVE READ THROUGH THIS LIST.**

- |                         |                              |                       |                    |
|-------------------------|------------------------------|-----------------------|--------------------|
| Heart Failure           | Artificial Joints/Prosthesis | Fainting/Dizzy Spells | Hay Fever          |
| Heart Disease or Attack | Anemia                       | Nervousness           | Sinus Trouble      |
| Chest Pain              | Stroke                       | Depression            | Allergies/Hives    |
| High Blood Pressure     | Kidney Trouble/Disease       | Psychiatric Treatment | Diabetes           |
| Heart Murmur            | Hepatitis                    | Sickle Cell Disease   | Thyroid Disease    |
| Mitral Valve Prolapse   | Liver Disease                | Glaucoma              | Arthritis          |
| Rheumatic Fever         | Yellow Jaundice              | Chemotherapy          | Cortisone Medicine |
| Heart Defects           | Blood Transfusion            | (Cancer/Leukemia)     | Pain in Jaw Joints |
| Scarlet Fever           | Drug Addiction               | Venereal Disease      | HIV Positive       |
| Artificial Heart Valve  | Hemophilia                   | Bruise Easily         | AIDS               |
| Heart Pacemaker         | Fever Blisters               | Emphysema             | Loss of Appetite   |
| Heart Surgery           | Epilepsy or Seizures         | Asthma                | Loss of Sleep      |
| Osteoporosis            |                              |                       |                    |

**CIRCLE any of the following medications you are allergic to or that have caused reactions:**

- |               |                             |            |
|---------------|-----------------------------|------------|
| Aspirin       | Local Anesthetic (Novocain) | Valium     |
| Nitrous Oxide | Codeine                     | Penicillin |
| Percodan      | Erythromycin                | Sulfa      |

List any other medications that you are knowingly allergic to or have had a bad reaction to: \_\_\_\_\_

List any medications you are currently taking: \_\_\_\_\_

Are you currently, or have you ever taking the drug **Fen Phen**?  YES  NO

LADIES: Are you currently **pregnant**, trying to conceive, or **nursing**? (PLEASE CIRCLE)  YES  NO

LADIES: **Are you currently taking Birth Control Pills**?  YES  NO

Is there any other medical information not included above which you feel we should be informed about?  YES  NO

If yes, please explain: \_\_\_\_\_

**DENTAL HISTORY**

1. What prompted you to seek dental care at this time? \_\_\_\_\_
2. How long has it been since your last thorough dental examination? \_\_\_\_\_
3. When were your teeth last cleaned? \_\_\_\_\_ X-rayed? \_\_\_\_\_
4. Has the fear of discomfort kept you from regular dental visits? \_\_\_\_\_
5. Are you satisfied with your past dentistry? \_\_\_\_\_
6. Have you had any bad experiences in a dental office? \_\_\_\_\_
7. Are you troubled with bad breath? \_\_\_\_\_
8. Do your gums bleed easily, feel tender or irritated? \_\_\_\_\_
9. Have you ever been treated for gum disease? \_\_\_\_\_
10. Are your teeth sensitive to hot, cold or sweets? \_\_\_\_\_
11. Do you often have sores or fever blisters in your mouth? \_\_\_\_\_
12. Are there areas in your mouth where food sticks or gets caught? \_\_\_\_\_
13. Are you self-conscious about the appearance of your teeth? \_\_\_\_\_
14. Do your jaws often feel tired or sore? \_\_\_\_\_ If yes, when do you notice this feeling? \_\_\_\_\_
15. Do you experience excessive headaches and/or pain in the neck, shoulders or back? \_\_\_\_\_
16. Do you experience clicking or popping noises when opening or closing your mouth, or when chewing food? \_\_\_\_\_
17. Are you aware of grinding or clenching your teeth? \_\_\_\_\_
18. Do you smoke? \_\_\_\_\_ If yes, how much? \_\_\_\_\_
19. **What, if anything, would you do to change the appearance of your teeth?** \_\_\_\_\_

**CONSENT**

I acknowledge that all of the above information is accurate to the best of my knowledge. I hereby authorize Dr. Jesse F. Head and/or the trained staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize Dr. Jesse F. Head and/or the trained staff to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents will be used when indicated and that this embodies a certain risk. I hereby give my permission to release any medical/dental information which may be indicated to process insurance claim forms or to receive proper treatment from other health specialists.

Signature of Patient / Parent or Guardian \_\_\_\_\_

Dr. Signature \_\_\_\_\_

Date \_\_\_\_\_



**PATIENT INFORMATION**

Patient Name: Dr. Mr. Mrs. Ms. Miss \_\_\_\_\_

By what name do you prefer to be called? \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security No: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address if different that above: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

If full time student, name & location of school: \_\_\_\_\_

Name of person responsible for account: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Employer Phone Number: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Nearest Relative Not Living With You: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

**INSURANCE INFORMATION**

First Insurance Company \_\_\_\_\_ Effective Date: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Employer: \_\_\_\_\_

SSN/ID #: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Group # / Policy #: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other

Second Insurance Company \_\_\_\_\_ Effective Date: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Employer: \_\_\_\_\_

SSN/ID #: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Group # / Policy #: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other

**(PLEASE COMPLETE THE BACK SIDE OF THIS FORM)**



Printed Patient Name \_\_\_\_\_

**FINANCIAL AGREEMENT**

Payment in full for all charges is required at time of visit, unless prior arrangements have been made.

**INSURANCE FILING**

You, the patient, are ultimately responsible for payment in full on your account, not the insurance company. We do, however, file dental insurance claims as a courtesy to our patients. We can only make estimates regarding your insurance benefits based on the information provided by you and the insurance company. In the event your insurance company does not pay as much as expected, the remaining balance is due and payable immediately by you, the patient

**ASSIGNMENT OF INSURANCE BENEFITS**

I/we hereby assign directly to Sonoran Vista Dentistry insurance benefits otherwise payable to me/us. I/we hereby authorize the release of any information relating to any claims. I/we are financially responsible for charges not paid by this assignment.

X

\_\_\_\_\_  
Responsible Party Signature

**DELINQUENT ACCOUNTS**

All delinquent accounts (30 days or older) are subject to reasonable service charges and/or legal interest rates.

**COLLECTION PROCEEDINGS**

In the event your account is turned over to a collection agency for non-payment or other delinquency, you will be responsible for payment of any collections costs and/or attorney fees, in addition to the balance owed. Any account turned over to a collection agency forfeits any past special fees and/or discounts. Such special fees and/or discounts will be reversed and you will be responsible for payment of regular fee for procedures at the time of service.

**FAILED APPOINTMENTS**

Failed appointments (less than 24-hour notice) are a significant contributor to rising healthcare costs. Individuals who fail to show for a confirmed appointment or give less than 24 hours notice may be assessed a fee of \$50.00 each occurrence.

X

\_\_\_\_\_  
Responsible Party Signature

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE**

I have received a copy of this office's Notice of Privacy Practices. I understand that I have a right to refuse to sign this acknowledgment.

X

\_\_\_\_\_  
Responsible Party Signature

**FOR MEDICARE ELIGIBLE PATIENTS ONLY**

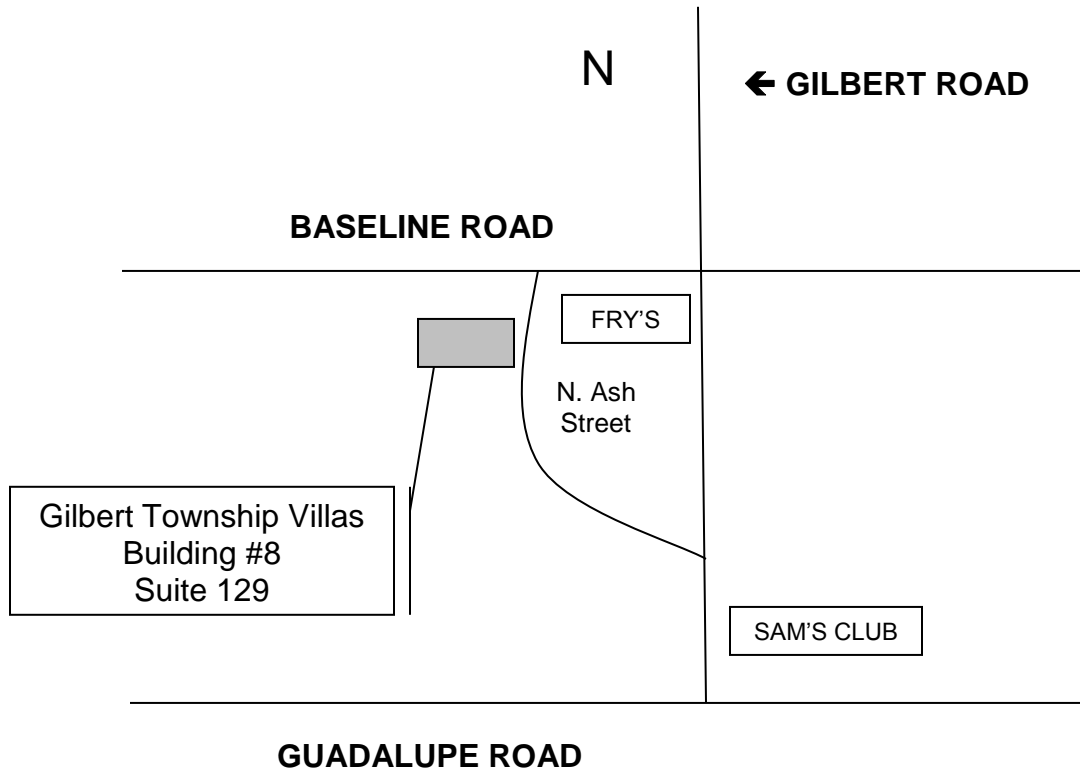
I understand that this office is a non-participating office with Medicare. I further understand that as a non-participating provider, Dr. Head will not submit insurance claims to Medicare on my behalf. I understand that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to services provided by Dr. Head.

X

\_\_\_\_\_  
Responsible Party Signature

# Sonoran Vista Dentistry

Jesse F. Head, DMD



**1757 East Baseline Road  
Building 8  
Suite 129  
(480) 545-0661**

**We are located in the Gilbert Township Villas Medical/Dental Plaza on the corner of N. Ash Street and Baseline Road.**