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

SONORAN | VISTA
DENTISTRY

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)

SONORAN VISTA DENTISTRY

Date_____

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 POLICY

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.

CANCELLATION POLICY

An appointment is an agreement between you & our office. Our part involves reserving the dentist, staff, and office time for you. Due to the ever increasing demand for our services, we kindly request that if you must reschedule an appointment please extend us the courtesy of ***48 hours notice***. This courtesy will make it possible to give your reserved time to another patient. Any failed appointment or cancellation with less than ***48 hours notice*** may be subject to a $50 fee. While we realize that emergencies do happen & are not anticipated, all efforts to notify us are greatly appreciated.

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

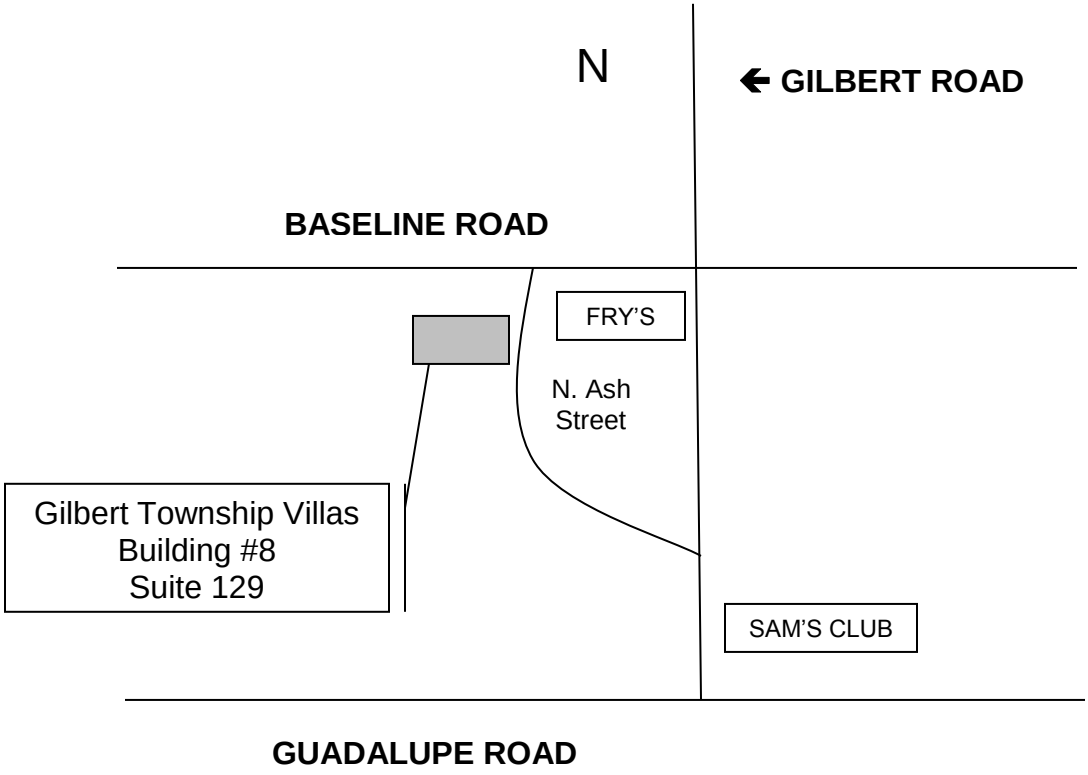
I understand that this office is a non-participating office with Medicare. I further understand that as a non-participating provider, Dr. Head will not submit insurance claims to Medicare on my behalf. I understand that neither Medicare's fee limitations nor any other Medicare reimbursement regulations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