NORTHERN ARIZONA PERIODONTICS
Dental Implants & Specialized Gum Care

COTTONWOOD
657 E Cottonwood Street, Suite 1
Cottonwood AZ, 86326
928 634 5033

WEST SEDONA
1146 W State Route 89A, Suite C3
Sedona AZ, 86336
928 282 2946

First Name (circle one Mr. Mrs. Ms. Dr.) ______ Middle Initial ______ Last Name ______ Preferred Name ______

Mailing Address ______ City ______ State ______ Zip Code ______

E-Mail Address ______ Main Phone ______ Cell Phone ______

Social Security Number ______ Birth Date ______ General Dentist's Name ______

Preferred Pharmacy ______ Pharmacy Address ______

Person Responsible for Account (if different) ______ Relationship ______ Phone Number ______ Birth Date ______

Authorization to Release Information / Emergency Contact: Those you choose to include in this section will be your emergency contact AND be authorized by you to discuss your treatment, past/scheduled appointments, and any other matter associated with your care, covered under the Privacy Practice at Northern Arizona Periodontics, with any member of our office staff.

Emergency Contact Name ______ Relationship ______ Emergency Contact's Phone Number ______

Emergency Contact Name ______ Relationship ______ Emergency Contact's Phone Number ______

DENTAL HISTORY

Approx. Month/Year of Last Dental Cleaning: ______ Current Dental Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

History: (✓ all that apply, provide approximate month/year of treatment)

☐ Orthodontic (Braces) ______
☐ Scaling/Root Planing (Deep Clean w/ Local Anesthesia) ______
☐ Periodontal (Gum) Surgery ______
☐ Trouble Getting Numb and/or had Reactions to Local Anesthetic
☐ Prefer to be Sedated for Dental Treatment
☐ Required to take antibiotics prior to dental care, reason: ______

Routine: (✓ all that apply)

☐ Floss ___ times/day ☐ Brush ___ times/day ☐ Electric Toothbrush ☐ Manual Toothbrush ☐ Water Pik ___ times/day

Symptoms: (✓ all that apply)

☐ Loose Teeth ☐ Shifting Teeth ☐ Bad Tastes ☐ Bad Breath ☐ Clicking/Popping in Jaw
☐ Clenching ☐ Grinding ☐ Bleeding Gums ☐ Heat Sensitivity ☐ Cold Sensitivity
☐ Sensitivity to Sweets ☐ Pressure Discomfort ☐ Brushing Sensitivity ☐ Flossing Sensitivity ☐ Other: ______

Any Problems Associated with Previous Dental Treatment? ☐ No ☐ Yes, explain: ______

By signing below I attest:

- **The above information on this form has been accurately answered and is true to the best of my knowledge.**
- **I understand providing incorrect information can be dangerous to my or the patient's health.**
- **I understand it is my responsibility to inform Northern Arizona Periodontics of changes to my/patient's medical status.**

Patient OR Patient's Legal Representative's Signature ______ Relationship ______

Patient Name (please print) ______ Birth Date ______ Today's Date ______

MEDICAL HISTORY (✓ all that apply for **past** and/or **current** conditions, note **date/details** if indicated with line)

☐ AIDS/HIV Positive	☐ Convulsions	☐ Heart Pacemaker	☐ Recent Weight Loss/Gain
☐ Alzheimer's/Dementia	☐ Cortisone Medicine	☐ Heart Trouble/Disease	☐ Renal Dialysis
☐ Anemia	☐ Diabetes: A1C _____________	☐ Hemophilia	☐ Rheumatic Fever
☐ Angina	☐ Diabetes: Family History	☐ Hepatitis _____________	☐ Scarlet Fever
☐ Arthritis/Gout	☐ Drug Addiction / Use	☐ High Blood Pressure	☐ Shingles
☐ Artificial Heart Valve	☐ Elevated Cholesterol	☐ Hives / Rash	☐ Sickle Cell Disease
☐ Artificial Joint	☐ Emphysema	☐ Irregular Heartbeat	☐ Sinus Trouble/Infection
☐ Asthma	☐ Epilepsy or Seizures	☐ Kidney Problems	☐ Sleep Apnea-CPAP? ___
☐ Blood Disease	☐ Excessive Bleeding	☐ Leukemia	☐ Sores/Growth in Mouth
☐ Blood Transfusion	☐ Fainting/Dizziness Spells	☐ Liver Disease	☐ Stroke _____________
☐ Bruise Easily	☐ Frequent Headaches	☐ Low Blood Pressure	☐ Thyroid Disease
☐ Cancer _________________	☐ Gastric Bypass Surgery	☐ Lung Disease	☐ Tuberculosis
☐ Chemotherapy / Radiation	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tumors or Growths
☐ Chest Pains	☐ Hay Fever	☐ Osteoporosis/Osteopenia	☐ Ulcers
☐ Cold Sores/Fever Blisters	☐ Heart Attack ______________	☐ Parathyroid Disease	☐ Other ______________
☐ Congenital Heart Disease	☐ Heart Murmur	☐ Psychiatric Care	☐ **None**

Women Only: ☐ Birth Control ☐ Trying to Get Pregnant ☐ Pregnant ☐ Nursing ☐ **None**

Medications:

Are you currently taking any medications or supplements? ☐ **No** ☐ **Yes**, please list: ____

____

Are you ALLERGIC to or REACTED ADVERSELY to any of the following? ☐ **No** ☐ **Yes** (✓all that apply) ☐ Other ________

☐ Aspirin	☐ Darvon	☐ Latex	☐ Nitrous Oxide	☐ Percodan	☐ Tetracycline
☐ Codeine	☐ Erythromycin	☐ Local Anesthetic	☐ Penicillin / Amoxicillin	☐ Sulfa	☐ Valium

Have you EVER taken any the following medications? ☐ **No** ☐ **Yes** (✓ all that apply, circle **P-Past**, **C-Current**, & list **duration**)

Blood Thinners:	☐ Coumadin:	P / C ________	Bisphosphonates:	☐ Actonel:	P / C ________
Typical INR: ____	☐ Eliquis:	P / C ________		☐ Alentronate (Fosamax):	P / C ________
	☐ Ibuprofen:	P / C ________		☐ Aredia:	P / C ________
	☐ NSAIDs:	P / C ________		☐ Boniva:	P / C ________
	☐ Paradaxa:	P / C ________		☐ Reclast:	P / C ________
	☐ Xarelto:	P / C ________		☐ Risedronate (Actonel):	P / C ________
	☐ Zometa:	P / C ________	Other:	☐ Herbal Supplements:	P / C ________

Tobacco Use: ☐ Never ☐ Quit: Year _____ ☐ Nicotine Vape ☐ Chew Tobacco ☐ Cigarettes/Cigars _______ /day

Present Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Unsure

Are you under a physician's care? ☐ No ☐ Yes, explain: ______________________________

Any changes in general health in the past year? ☐ No ☐ Yes, explain: ______________________________

Any serious illness/hospitalization in the last 5 years? ☐ No ☐ Yes, explain: ______________________________

______________________ Primary Care Doctor ______________________ City, State ______________________ Date of Last Medical Exam

OFFICIAL USE ONLY __________ Reviewed ______ Date

By signing below I attest:

- **The above information on this form has been accurately answered and is true to the best of my knowledge.**
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- **I understand it is my responsibility to inform Northern Arizona Periodontics of changes to my/patient's medical status.**

____ Patient OR Patient's Legal Representative's Signature ______________ Relationship

______________________________ Patient Name (please print) ______________ Birth Date ______________ Today's Date

DENTAL INSURANCE ☐ **None**

For an accurate insurance estimation, please complete this section as much as you can.

Primary Dental Insurance

______________________	______________________	______________________	______________________
Subscriber Name	Subscriber Date of Birth	Subscriber Number	Relationship
______________________	______________________	______________________	______________________
Insurance Company Name	Group Number	Insurance Phone Number	Subscriber Employer

Secondary Dental Insurance

______________________	______________________	______________________	______________________
Subscriber Name	Subscriber Date of Birth	Subscriber Number	Relationship
______________________	______________________	______________________	______________________
Insurance Company Name	Group Number	Insurance Phone Number	Subscriber Employer

OFFICE POLICIES

Thank you for choosing **Northern Arizona Periodontics** to serve your periodontal needs. We are committed to providing you with the highest quality dental care, so that you may attain optimum oral health. The following is a statement of our Payment, Insurance, Cancelation, Fee Guarantee, Communication, and Privacy Practice policies, which we require that you read and sign prior to any treatment.

Payment Policy: I understand that 50% of the estimated patient portion is required upon scheduling of treatment. **The other 50%, payment in full, is required 48 hours prior to my scheduled appointment to avoid cancellation**. After an insurance claim is finalized, any remaining balance over 90 days may accrue service charges. Any finance, late, re-billing, collection charge, and/or attorney fee will be added to any overdue balance and must be paid by me.

Insurance Policy: I understand that the office is contracted as a Delta Dental PPO Provider only, and that as a courtesy, Northern Arizona Periodontics, will submit all dental insurance claims, on **my** behalf, for **up to two** insurance providers. I understand that insurance estimates are a best guess based on information my insurance company provided, does not include recent dental claims from other offices, and is not a guarantee that my insurance will pay exactly as estimated. Under no circumstances will any insurance company guarantee payment prior to treatment. **I am responsible for any and all costs that will not be covered by my insurance plan.**

Insurance Claims: I authorize my insurance company to pay my dental dental benefits.

Cancelation Policy: I understand that 48-business hour notification is required for any and all appointment cancellations, otherwise a cancellation fee of $75 may be assessed to my account. Leaving a message does not qualify as notification. Unusual circumstances will be considered on a case-by-case basis.

Fee Guaranteed Policy: I understand fees on my treatment plan will be valid for **90 days following the printed date of my treatment plan**. Beyond the 90 days, my treatment plan may be subject to increases/decreases in fees and may no longer qualify for any discounts given.

Medicare Policy: I understand that Northern Arizona Periodontics has opted out of Medicare and is not contracted with nor is a provider for Medicare.

Privacy Practices Policy: By signing below, I acknowledge that I received a copy of the Notice of Privacy Practices.

☐ **I refused to acknowledge the Notice of Privacy Practices**

By signing below I attest:

- **I acknowledge that I have fully read, understand, and accept the policies listed above in their entirety.**
- **The above information on this form has been accurately answered and is true to the best of my knowledge.**
- **I understand it is my responsibility to inform Northern Arizona Periodontics of changes to my/patient's medical status.**

______________________________________		______________________
Patient OR Patient's Legal Representative's Signature		Relationship
______________________________________	______________________	______________________
Patient Name (please print)	Birth Date	Today's Date