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 | Cell Phone

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

Preferred Pharmacy (local - no mail-order pharmacies) | 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 Practices at Northern Arizona Periodontics, with any member of our office staff.

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

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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
☐ Alzheimer's/Dementia
☐ Anemia
☐ Angina
☐ Arthritis
☐ Artificial Heart Valve
☐ Artificial Joint _____ Date/Location
☐ Asthma
☐ Blood Disease
☐ Blood Transfusion
☐ Bruise Easily
☐ Cancer _____ Date/Type
☐ Chemotherapy
☐ Radiation
☐ Cold Sores/Fever Blisters
☐ Congenital Heart Disease

☐ Convulsions
☐ Cortisone Medicine
☐ Diabetes: A1C _____ Date/Current #
☐ Drug Addiction/Use
☐ Diabetes: Family History
☐ Elevated Cholesterol
☐ Emphysema
☐ Epilepsy or Seizures
☐ Excessive Bleeding
☐ Fainting/Dizziness Spells
☐ Frequent Headaches
☐ Gastric Bypass Surgery
☐ Glaucoma
☐ Seasonal Allergies
☐ Heart Attack _____ Month/Year
☐ Heart Murmur

☐ Heart Pacemaker
☐ Heart Trouble/Disease
☐ Hemophilia
☐ Hepatitis _____ Type
☐ Hives / Rash
☐ High Blood Pressure
☐ Irregular Heartbeat
☐ Kidney Problems
☐ Leukemia
☐ Liver Disease
☐ Chest Pains
☐ Lung Disease
☐ Mitral Valve Prolapse
☐ Osteoporosis/Osteopenia
☐ Parathyroid Disease
☐ Psychiatric Care

☐ Recent Weight Loss/Gain
☐ Renal Dialysis
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Shingles
☐ Sickle Cell Disease
☐ Sinus Trouble/Infection
☐ Sleep Apnea-CPAP? Y / N
☐ Sores/Growth in Mouth
☐ Stroke _____ Date
☐ Tuberculosis
☐ Thyroid Disease
☐ Tumors or Growths
☐ Ulcers
☐ Gout
☐ **None** ☐ Other _____

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)

☐ Aspirin ☐ Darvon ☐ Valium ☐ Percodan ☐ Tetracycline
☐ Codeine ☐ Erythromycin ☐ Local Anesthetic ☐ Penicillin / Amoxicillin ☐ Sulfa ☐ Other _____

Have you EVER taken any the following medications? ☐ **No** ☐ **Yes** (✓ all that apply)

Blood Thinners:
Typical INR: _____
☐ Coumadin
☐ Eliquis
☐ Ibuprofen/NSAIDs
☐ Paradaxa
☐ Xarelto

Other:
☐ Herbal Remedies/Supplements

Osteoporosis Rx:
☐ Prolia/Xgeva
☐ Alendronate/Fosamax
☐ Aredia
☐ Forte
☐ Boniva/Ibandronate
☐ Reclast/Zometa
☐ Risedronate /Actonel

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

Cannabis Use: ☐ Never ☐ Quit: Year _____ ☐ Vape/Smoke ☐ Edibles/Capsules ☐ Amount used _____ /day

Are you under a physician's care? ☐ 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

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

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

DENTAL INSURANCE ☐ None

In order for us to submit a claim, on your behalf, to your insurance company, please complete this section in its **entirety**.

Primary Dental Insurance

☐ Self ☐ Parent ☐ Spouse

Subscriber Name	Subscriber Date of Birth	Subscriber Number	Relationship

Insurance Company Name

Secondary Dental Insurance

☐ Self ☐ Parent ☐ Spouse

Subscriber Name	Subscriber Date of Birth	Subscriber Number	Relationship

Insurance Company Name

OFFICE POLICIES

Payment Policy: I understand that a 50% deposit is required when scheduling any surgical appointment, with the remaining 50% due two weeks prior to the appointment to avoid cancellation. I acknowledge that treatment will not proceed unless full payment has been received.

Dental Insurance: I understand that Northern Arizona Periodontics, as a courtesy, will submit all claims of me to most insurance companies. I understand that I am to pay Northern Arizona Periodontics directly and upfront for any treatment and any insurance benefit coverage reimbursement will be sent directly to me. I understand that Northern Arizona Periodontics is not contracted with any insurance company. I understand if I have dual insurance, I must provide my primary insurances explanation of benefits (EOB) to the office in order to facilitate submission of a secondary claim. I understand that Northern Arizona Periodontics will not provide estimated insurance coverage information and that I must contact my insurance directly should I want to know what, if any of my treatment is covered.

Medical Insurance: I understand that medical claims will not be submitted by this office.

Cancellation Policy: I understand that a 48-hour business notice is required for all cancellations. If I do not provide this notice, a cancellation fee of **$75** for hygiene appointments and **$150** for surgical appointments 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 Guarantee Policy: I understand that fees (and discounts) listed on my treatment plan are valid for 90 days from the printed date. After 90 days, my treatment plan may be subject to fee adjustments. Additionally, I understand that treatment plans extending beyond **18 months** will require a new evaluation at the current comprehensive evaluation fee.

Medicare Policy: I understand that Northern Arizona Periodontics has opted out of Medicare/Medicaid (AHCCCS) and is not a contracted provider for Medicare and will not submit dental claims to these entities.

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

☐ I refuse 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