NORTHERN ARIZONA PERIODONTICS
Dental Implants & Specialized Gum Care

COTTONWOOD
657 E Cottonwood Street, Suite 1
Cottonwood AZ, 86326

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

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

*If the patient is 18 or older, please provide documentation of power of attorney and driver's license.

**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

**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

## DENTAL INSURANCE

☐ **None** *In order for us to submit a claim, this section is required to be completed.

**Dental Insurance**

| Insurance Company | Subscriber Name | Date of Birth | Subscriber/Member ID | Relationship |
|---|---|---|---|---|
| | | | | |
| Insurance Company | Subscriber Name | Date of Birth | Subscriber/Member ID | Relationship |
| | | | | |

## OFFICE POLICIES

**Payment Policy**:
- Surgical appointments require a 50% deposit
- The remaining amount is due 2 weeks prior to the appointment
- Full payment is required to proceed with treatment

**Dental Insurance:**
- The office will submit claims to most dental insurance companies.
- Any insurance reimbursement is sent directly to the patient.
- The office is not contracted with any insurance company.
- The office will not submit claims for **HMO, DMO, Medicare, Medicaid,** or **AHCCCS**.

**Additional Dental Insurance:**
- Patients must provide the explanation of benefits (EOB) from the primary carrier for a secondary claim to be submitted
- Tertiary claims are the responsibility of the patient

**Medical Insurance:**
- Medical insurance claims are not submitted by this office.

**Medicare/Medicaid Policy**:
- Northern Arizona Periodontics has **opted out** of Medicare and Medicaid (AHCCCS).

**Cancellation Policy**:
- **48 business hours' notice** is required for all cancellations.
- Failure to provide notice may result in a fee of **$75** for hygiene or **$150** for surgical appointments.
- Leaving a voicemail message does not qualify as notification.
- Unusual circumstances will be considered on a case-by-case basis.

**Fee Guarantee Policy**:
- Fees (and discounts) listed on treatment plans are valid for **90 days** from the printed date.
- After 90 days, treatment plans may be subject to fee adjustments.
- Treatment plans beyond **18 months** require a new evaluation at the current evaluation fee.

**Pre-Determinations:**
- Submitted at the request of the patient
- Is an estimate only, not a guarantee, is often inaccurate and delays care.

**Pre-Authorizations:**
- On rare occasions, some plans (ie. union-based, workers comp, etc) may require a pre-authorization before treatment
- Is a formal approval by insurance for specific treatment
- Patients must contact the insurance company directly to confirm if this applies.

**Diagnostic Imaging**
- A full mouth x-ray series (FMX) taken within one year is required for all periodontal patients.
  - An FMX from another office may be used if complete and diagnostic.
  - If taken in office, the fee is **$190**.
- A 3D Scan (CBCT) is required for all implant candidates and some lower jaw extractions.
  - If taken in office, the fee is **$270**.

**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.**
- **I have access to the Notice of Privacy Practices of Northern Arizona Periodontics, and I may request a copy at any time.**

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