



Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Soc. Sec. # _____
Last Name First Name Middle Initial

Address _____ Home Phone _____

City _____ State _____ Zip _____ Email _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____ Work Phone _____

Cell Phone _____ Business Email _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber's # _____

Name(s) of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? Yes No

Subscriber's Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Business Phone _____

Subscriber Employed by _____ Business Email _____

Insurance Company _____ Phone _____ Insurance Email _____

Contract # _____ Group # _____ Subscriber's # _____

Name(s) of other dependents under this plan _____

Please complete both sides





Dental History

What would you like us to do today? _____

Are you in dental discomfort today? _____

Former Dentist _____ Address _____ Phone _____

Dentist's Email _____

Date of last dental care _____ Date of last X-rays _____

Check Y for yes or N for no if you have or have not had the following:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Bad breath | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to sweets | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to cold | <input type="checkbox"/> Y <input type="checkbox"/> N Loose teeth or broken fillings |
| <input type="checkbox"/> Y <input type="checkbox"/> N Food collection between teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding gums | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity when biting | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to hot |
| <input type="checkbox"/> Y <input type="checkbox"/> N Periodontal treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Grinding or clenching teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Clicking or popping jaw | <input type="checkbox"/> Y <input type="checkbox"/> N Sores or growths in mouth |

How often do you brush? _____ How often do you floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Y N

Medical History

Physician's name _____ Address _____ Phone _____

Physician's Email _____

Date of last visit _____ Have you had any serious illnesses or operations? Y N If yes, describe _____

Are you currently under physician care? Y N If yes, describe _____

Have you ever had a blood transfusion? Y N If yes, give approximate date(s) _____

Have you ever taken Fen-Phen/Redux? Y N

Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Check Y for yes or N for no if you have or have not had the following:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Positive | <input type="checkbox"/> Y <input type="checkbox"/> N Cough, persistent | <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anaphylaxis | <input type="checkbox"/> Y <input type="checkbox"/> N Cough up blood | <input type="checkbox"/> Y <input type="checkbox"/> N Jaw pain | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney disease or malfunction | <input type="checkbox"/> Y <input type="checkbox"/> N Skin rash |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis, Rheumatism | <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Liver disease | <input type="checkbox"/> Y <input type="checkbox"/> N Spina Bifida |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial heart valves | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting | <input type="checkbox"/> Y <input type="checkbox"/> N Material allergies | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial joints | <input type="checkbox"/> Y <input type="checkbox"/> N Food allergies | (latex, wool, metal, chemicals) | <input type="checkbox"/> Y <input type="checkbox"/> N Surgical implant |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral valve prolapse | <input type="checkbox"/> Y <input type="checkbox"/> N Swelling of feet or ankles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Atopic (allergy prone) | <input type="checkbox"/> Y <input type="checkbox"/> N Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Nervous problems | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease or malfunction |
| <input type="checkbox"/> Y <input type="checkbox"/> N Back problems | <input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker/Heart surgery | <input type="checkbox"/> Y <input type="checkbox"/> N Tobacco habit |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood disease | <input type="checkbox"/> Y <input type="checkbox"/> N Heart problems | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric care | <input type="checkbox"/> Y <input type="checkbox"/> N Tonsillitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | Describe _____ | <input type="checkbox"/> Y <input type="checkbox"/> N Rapid weight gain or loss | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemical dependency | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/
Abnormal bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcer/Colitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes | <input type="checkbox"/> Y <input type="checkbox"/> N Respiratory disease | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Circulatory problems | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic fever | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cortisone treatments | | <input type="checkbox"/> Y <input type="checkbox"/> N Scarlet fever | |

List medications you are currently taking, if any: _____

List drug allergies, if any: _____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.



Artistic Design Family Dentistry
9377 East Bell Road St #347
Scottsdale, AZ 85260
(480) 563-0525
www.AZFamilyDDS.com

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

***You May Refuse to Sign This Acknowledgement**

I, _____, have received a copy of this office's Notice of Privacy Practices.

(Please Print)

(Signature)

(Date)

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

Artistic Design Family Dentistry

9377 E. Bell Rd. Suite #347

Scottsdale, AZ 85260

APPOINTMENTS AND CANCELLATIONS POLICY

When we schedule an appointment for you, we are preparing your records, readying special instruments for your visit as well as reserving a specific amount of time for the doctor and staff to tend to your particular dental needs. Artistic Design Family Dentistry (ADFD) will not cancel or reschedule your appointment and we ask for the same courtesy from you. Except for emergency treatment being performed on another patient, you can expect us to be prompt and seat you at your appointed time. We, of course, would appreciate the same courtesy from you by arriving early to your appointment so you can update any necessary information and still be seated at your appointed time.

Please understand that the fee we charge for late cancellations/no-shows only partially covers our costs. While we completely understand that "life happens" and some things are uncontrollable, we ask that our patients also understand that we as a business, must keep our commitment(s) to the other patients in our practice as well as our team of employees. We must pay our employees for their time, whether or not a patient keeps their appointment. When a patient cancels with less than 48 hours notice (late cancellation) or no shows an appointment, we also lose the opportunity to schedule other patients that are in need of dental treatment, which results in higher cost(s) to do business, thus increasing patient fees.

_____ I understand that ADFD reserve the right to charge for late cancellations as well as not showing up for scheduled appointments.

_____ I understand that repeated rescheduling of appointments, late cancellation of appointments or missed appointments may result in dismissal from the practice.

Printed Name _____

Date _____

Signature _____

Artistic Design Family Dentistry

Office Policies

Please read and initial each item listed with regards to our office financial policy. Please feel free to ask us any questions with regards to this form.

- I understand Dr. Trowbridge will diagnose and treat my conditions according to the professional standard of care and her expertise, not according to what my insurance carriers' recommendation may be or what the insurance may cover/pay for. _____ Int.
- I further understand, due to the philosophy of the practice, a minimum of 48 hours notice for missed appointments is required. If proper notice is not given to the office, there will be a missed appointment fee of \$50 per hour to cover time and material set up for appointments that are subsequently lost/wasted. This fee may be waived at the offices' discretion. ALL treatment appointments will require a 30% deposit to be scheduled. Three missed appointments may result in dismissal from the practice. _____ Int.
- As a courtesy, the office will bill my insurance carrier at the time services are provided. I understand that my insurance company may request additional information in order to process claims and that I will promptly respond to such requests. I understand that patient portions are only an estimate and are due at time of service. _____ Int.
- I understand my insurance may not cover all services/materials provided for my health benefit and I am responsible for the payment of any unpaid balances on my account. I understand that co-payments are due at time of service and are subject to late fees if not paid at time of service. _____ Int.
- I understand that any balance generated following an insurance payment is due within 10 days of the billing date on the statement. Finance charges will be applied to all balances over 30 days in the amount of \$30 or 10% of the balance, whichever is higher. _____ Int.
- I realize that failure to keep this account current may result in Artistic Design Family Dentistry being unable to provide additional services and after 90 days all outstanding balances will be directly assigned to collection services. _____ Int.
- In the case of default on payment of this account, I agree to pay collection costs (30% of the balance sent to collections) and any attorney fees, or court costs incurred in attempting to collect outstanding account balances. _____ Int.
- Dr. Tatiyana Trowbridge often takes photographs for the purposes of case documentation, laboratory communication, continuing education, lectures, slide presentations, before and after pictures and various dental and other articles or publications. I hereby grant permission the use of any and all photography and x-rays to Dr. Tatiyana Trowbridge and Artistic Design Family Dentistry. I also acknowledge that this is done voluntarily, without compensation and my name and all other privacy information will be held confidential. _____ Int.

By signing below I agree to all terms above.

Signature of Patient or Guardian and Patient

Date