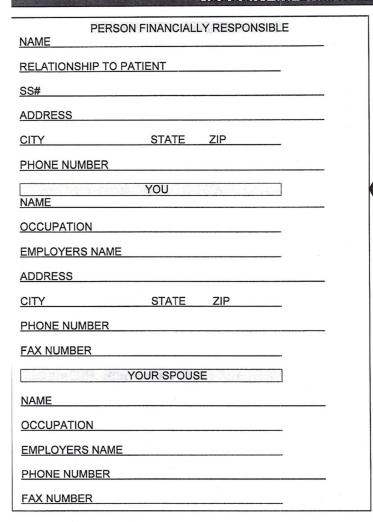
Su	Tacco	VICI	+	
200		E N		L

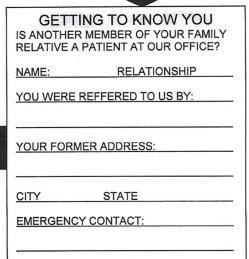
PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

Date			
LAST NAME	FIRST		MI
PREFERS TO BE CALLED B	Y:		
ADDRESS:			
CITY	STATE	ZIP	
HOME PHONE	CELL PHONE		
DATE OF BIRTH	AGE MALE	FEMALE	
MARRIED SINGLE	DIVORCED	WIDOWED	
SOCIAL SECURITY#			
(IF STUDENT) SCHOOL If you	our child's last name and/or the same as yours, please		
EMAIL ADDRESS:	the same as yours, please	Tet us know.	
WOULD YOU LIKE TO RECI	FIVE TEXT MESSAGES	TO CONFIRM APPT	Γ?

INSURANCE COMPANY INSURANCE COMPANY INSURANCE PHONE# GROUP NUMBER EMPLOYER NAME SUBSCRIBER NAME DATE OF BIRTH: RELATION TO PATIENT ID# SUBSCRIBER'S SS#

ACCOUNT INFORMATION





CLOSEST RELATIVE NOT LIVING WITH

STATE

STATE

PHONE NUMBER

PHONE NUMBER

ADDRESS

ADDRESS

CITY

YOU:

Suncoast MEDICAL HISTORY

Have you been under the c	are of	a me	dical doctor during the pas	t two y	ears?	Yes	No	
If yes, what for?			· D1					
Physician's NameAddress			Phone	C4	4.	7:		
Address			City	Sta	ate	Zıp		
Date of Last Dental Exam:	·							
Date of Last Dental X-Ray	'S:							
If Wearing Dentures How	Old A	re Th	ney:					
Are you taking medication							NI.	
counter herbal medicines							NO	
PLEASE LIST:								
**			6 . 1.1 . 1 1	r r	1			
Have you ever taken any p	rescri	ption	s for weight loss, including	ren-P	nen		NI-	
(fenfluramine-phentermine	e), Poi	ndime	en (fenfluramin), and Redu	x (dex	tenflur	amine)? Y es	No	
				1.	.•	1	N T-	
> Are you aware of having a							No	
If yes, please list								
				. ~.	- "			
Indicate which of the follow	ing yo	ou ha	ve had, or have at presen	t. Circ	le "yes	or "no to each of them.	<u> </u>	
Heart (surgery, disease, attack)	Yes	No.	Diabetes	Yes	No	Blood Transfusion	. Yes	No
Chest Pain	Yes	No	Thyroid Problems	Yes	No	Hemophilia	Yes	No
Congenital Heart Disease	Yes	No	Emphysema	Yes	No	Sickle Cell Disease	Yes	No
Heart Murmur	Yes	No	Latex Allergy	Yes	No	Bruise Easily Liver Disease	Yes Yes	No No
High Blood Pressure Mitral Valve Prolapse	Yes Yes	No No	Chronic Cough	Yes	No	Yellow Jaundice	Yes	No
Artificial Heart Valve	Yes	No	Tuberculosis	Yes	No No	Neurological Disorders	Yes	No
Heart Pacemaker	Yes	No	Asthma Allergies or Hives	Yes Yes	No	Epilepsy or Seizures	Yes	No
Rheumatic Fever	Yes	No	Sinus Trouble	Yes	No	Fainting or Dizzy Spells	Yes	No
Arthritis / Rheumatism	Yes	No	Radiation Therapy	Yes	No	Nervous/Anxiety	Yes	No
Cortisone Medicine	Yes	No	Chemotherapy	Yes	No	Psychiatric Treatment Herpes	Yes Yes	No No
Swollen Ankles	Yes Yes	No No	Cancer	Yes	No	Depression	Yes	No
Diet (special/restricted)	Yes	No	Hepatitis A B C (circle) Venereal Disease	Yes Yes	No No	Sulfa Allergy	Yes	No
Artificial Joints (hip,knee,etc)	Yes	No	HIV / A.I.D.S	Yes	No	Ulcers	Yes	No
Kidney Trouble	Yes	No	Cold Sores	Yes	No	Bisphosphonate	Yes	No
> Do you have any prior or	currer	it hist	ory of substance abuse?			Yes	No	
Do you use any forms of	obacc	o pro	ducts?			Yes	No	
> Do you have or have you	had ar	ny dis	ease condition or problem	not lis	ted?	Yes	No	
~^ ~! ~!			· · · · · · · · · · · · · · · · · · ·					
> Women: Are you pregna	int or t	think	you may be pregnant? You	es	Mon	ths No		
			Y6		No			
Do you use birt	h cont	rol m	edications?Y	es	No			
•								
I understand the above info	rmatic	on is r	necessary to provide me wi	th deni	tal care	e in a safe and efficient ma	nner. I	have
answered all questions to th	e best	of m	knowledge. Should furthe	r infor	mation	be needed, you have my p	ermissi	on to
ask the respective health car								
•	•		ny changes in my health or					
Print Name			Date					
· · · · · · · · · · · · · · · · · · ·			Date					
Dation (/ C	Ci	4						
ratient/Guardian S	oigna'	.ure						

SUNCOAST DENTAL TMJ QUESTIONAIRE

	POPPING	YES	NO			
•	CLICKING	YES	NO			
•	HEADACHES	YES	NO			
•	TOP OF SHOULDER PAIN	YES	NO			
•	EARACHES	YES	NO			
1.	Have you ever had trauma to Ex: Fall down hitting jaw etc If yes please explain:		ead or neck a	rea?	Yes	NO
						_
				· · · · · ·		-
	Print name:	- A - Toronto				
			_			
	Signature:		Date	5		

SUNCOAST DENTAL

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: Patient Giving Consent
Name:
Address:
SECTION B: PATTENT — PLRASE READ THE FOLLOWING CAREFULLY Purpose of Consent: By signing the form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide to sign this Consent. Our Notice provides a description of our treatment, payment activities, healthcare operations, the uses and disclosures we may make of your protected health information, and other important matters concerning your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information we maintain.
You may obtain a copy of our Notice of Privacy Practices, including any revisious, by contacting:
Suncoast Dental
2025 N. Pebble Creek Pkwy #A-11 Goodyear AZ 85395.
(623) 698-4020
I,
Signature: Date:
If patient is a minor, or a personal representative is signing this form please complete the following:
Personal representative's name:
Relationship to Patient: YOU ARE ENTITLED TO A COPY OF THIS COSENT AFTER YOU SIGN IT
REVOCATION OF CONSENT:

You have the right to revoke your consent at anytime by giving us written notice of your revocation. Submit your revocation to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent, before we received your revocation. Also understand that we may decline to treat you or continue treating you if you revoke this consent.

REFUSAL TO SIGN:

If you refuse to sign this form, understand that we may not be able to treat you. Some methods of treatment require us to release your information. If we are able to treat you it will be as a cash only basis.

Suncoast Dental Financial policy

I hereby authorize doctor or designated staff to take x-rays, study models, radiographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs. Upon agreement of recommended treatment, I understand the use of anesthetics, sedatives and other medication may be necessary. I fully understand that using anesthetic agents embodies certain risks and I have the right to ask for a complete recital of any possible complications.

I understand it is my responsibility to pay for all dental treatment provided in this office for myself
and dependents at the time of services, unless prior written arrangements have been made. In the
event that payment is not received on the agreed upon dates, I understand that a 1.5% monthly
finance charge (18% APR) will be added to my account for balance over thirty (30) days old.

I understand that Suncoast Dental will file for services rendered to my insurance carrier as a courtesy, but my insurance coverage is a contract between my insurance carrier and myself, and any financial quotes given by this office are estimates. Some services are not covered by my insurance carrier and any remaining balance unpaid or denied by my insurance company is ultimately my responsibility.

understand that Suncoast Dental accepts cash, all major credit cards, personal checks and Care Credit as forms of payment for my account. We do not have "In house" payment arrangements.

I understand that a \$35.00 "non-sufficient Funds Fee" will be added to my account in the event of a returned check is received from our bank.

I understand that in the event my account becomes delinquent and is then assigned to an outside collection agency, a 35% collection fee based on the balance plus all applicable finance charges will be added.

I understand that \$25.00 per reserved hour will be charged to my account for "Failed", "Broken", or "Rescheduled" appointments I or my dependants have without giving 24 hour notice.

I understand that it is my responsibility to advise the office of any changes in the information regarding my patient information, insurance information and health history.

I understand that a \$25.00 fee may be applied to my account for duplication of my dental X-rays.

Date:		

SUNCOAST DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgment

	, have received a copy of this office Notice of Privacy Practices.
Signat	ture:
	Date:
	FOR OFFICE USE ONLY
-	to obtain written acknowledgement of receipt of our Notic
-	actices, but acknowledgement could not be obtained for the
-	
-	actices, but acknowledgement could not be obtained for the following reasons: Individual refused to sign Communication barriers prohibited us
-	actices, but acknowledgement could not be obtained for the following reasons: Individual refused to sign Communication barriers prohibited us An emergency situation prevented us
-	actices, but acknowledgement could not be obtained for the following reasons: Individual refused to sign Communication barriers prohibited us