Suncoast DENTAL

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

Date ____________

LAST NAME ____________ FIRST ____________ MI ____

PREFERS TO BE CALLED BY: ____________

ADDRESS: ____________

CITY ____________ STATE ____________ ZIP ____________

HOME PHONE ____________ | CELL PHONE ____________

DATE OF BIRTH ____________ AGE ____ MALE ____ FEMALE ____

MARRIED ____ | SINGLE ____ | DIVORCED ____ | WIDOWED ____

SOCIAL SECURITY# ____________

(IF STUDENT) SCHOOL ____________ GRADE ____

If your child's last name and/or address are not the same as yours, please let us know.

EMAIL ADDRESS: ____________

WOULD YOU LIKE TO RECEIVE TEXT MESSAGES TO CONFIRM APPT? ____________

DENTAL INSURANCE

INSURANCE COMPANY ____________

INSURANCE PHONE# ____________

GROUP NUMBER ____________

EMPLOYER NAME ____________

SUBSCRIBER NAME ____________

DATE OF BIRTH: ____________

RELATION TO PATIENT ____________

ID# ____________

SUBSCRIBER'S SS# ____________

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE

NAME ____________

RELATIONSHIP TO PATIENT ____________

SS# ____________

ADDRESS ____________

CITY ____________ STATE ____ ZIP ____

PHONE NUMBER ____________

YOU

NAME ____________

OCCUPATION ____________

EMPLOYERS NAME ____________

ADDRESS ____________

CITY ____________ STATE ____ ZIP ____

PHONE NUMBER ____________

FAX NUMBER ____________

YOUR SPOUSE

NAME ____________

OCCUPATION ____________

EMPLOYERS NAME ____________

PHONE NUMBER ____________

FAX NUMBER ____________

GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY RELATIVE A PATIENT AT OUR OFFICE?

NAME: ____________ RELATIONSHIP ____________

YOU WERE REFFERED TO US BY: ____________

____

YOUR FORMER ADDRESS: ____________

____

CITY ____________ STATE ____________

EMERGENCY CONTACT: ____________

____

PHONE NUMBER ____________

ADDRESS ____________

CITY ____________ STATE ____________

CLOSEST RELATIVE NOT LIVING WITH YOU: ____________

PHONE NUMBER ____________

ADDRESS ____________

CITY ____________ STATE ____________

MEDICAL HISTORY

Suncoast DENTAL

- Have you been under the care of a medical doctor during the past two years?.......................... Yes No

  If yes, what for?____

  Physician's Name_____________________________ Phone_____________

  Address _________________________ City__________________ State _____ Zip _________

  Date of Last Dental Exam: ___________

  Date of Last Dental X-Rays: __________

  If Wearing Dentures How Old Are They: _______

- **Are you taking medication or drugs currently, including regular doses of aspirin or over the counter herbal medicines?** .... Yes No

  PLEASE LIST:____

  ____

  Have you ever taken any prescriptions for weight loss, including Fen-Phen (fenfluramine-phentermine), Pondimen (fenfluramin), and Redux (dexfenfluramine)?............... Yes No

- Are you aware of having an allergic (or adverse) reaction to any medication or substance?.......... Yes No

  If yes, please list ____

Indicate which of the following you have had, or have at present. Circle "yes" or "no to each of them.

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...............	Yes	No
High Blood Pressure...............	Yes	No	Chronic Cough.............	Yes	No	Liver Disease...............	Yes	No
Mitral Valve Prolapse............	Yes	No	Tuberculosis...............	Yes	No	Yellow Jaundice.........	Yes	No
Artificial Heart Valve...........	Yes	No	Asthma......................	Yes	No	Neurological Disorders....	Yes	No
Heart Pacemaker.....................	Yes	No	Allergies or Hives.........	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......	Yes	No
Swollen Ankles......................	Yes	No	Cancer.......................	Yes	No	Herpes.......................	Yes	No
Stroke................................	Yes	No	Hepatitis A B C (circle)	Yes	No	Depression	Yes	No
Diet (special/restricted)............	Yes	No	Venereal Disease...........	Yes	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 current history of substance abuse?...................................... Yes No
- Do you use any forms of tobacco products?.. Yes No
- Do you have or have you had any disease condition or problem not listed? .... Yes No

  If yes, Please List:____

- **Women:** Are you pregnant or think you may be pregnant? Yes _____Months No_______

  Are you nursing?.. Yes No

  Do you use birth control medications?............... Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency that may release such information to you. I will notify the dentist of any changes in my health or medications.

Print Name ________________________________ **Date** __________________

Patient/Guardian Signature ____

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 the head or neck area? Yes NO
   Ex: Fall down hitting jaw etc.
   If yes please explain:

   ____

   ____

   ____

Print name: ________________________

Signature: __________________________ Date__________

SUNCOAST DENTAL

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: Patient Giving Consent

Name:____

Address:____

SECTION B: PATIENT – PLEASE 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 revisions, by contacting:

Suncoast Dental
2025 N. Pebble Creek Pkwy #A-11
Goodyear AZ 85395.
(623) 698-4020

I, ________________________________, have had full opportunity to read and consider the Consent form and your Notice of Privacy Practices. I understand that, by signing the Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment.

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.

Signature: ______________________________________

Date: ____________________

Relationship (if minor or guardian): ________________________

SUNCOAST DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgment

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

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 for the following reasons:

____ Individual refused to sign
____ Communication barriers prohibited us
____ An emergency situation prevented us
____ Other (please specify below)

____

____