5590 W Chandler Blvd #1
Chandler, AZ 85226
P: 480-821-4000
F: 480-893-7764

Welcome To Our Office!

To help us meet all your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Name ______________________________ Date ______________

Soc. Sec. # ______________ Birthdate __________ Home Phone ______________ Cell # ______________

Address ______________________________ Apt# ______________

City ______________________ State ______________ Zip ______________

Email ______________________ Driver's License # ______________

When confirming appointments how do you prefer to be contacted? ☐ Phone ☐ Email ☐ Text Message

Patient's or Parent's Employer ______________ Work Phone ______________

Business Address ______________ City ______________ State __________ Zip __________

Spouse or Parent's Name ______________ Employer ______________ Work Phone ______________

How did you hear about our office? (Check All That Apply)

☐ Google ☐ Yelp ☐ Website ☐Insurance Company ☐ Drive By ☐ ZocDoc ☐ Facebook

☐ Friend ______________________ ☐ Patient ______________________

Responsible Party

Responsible Party for this Account ______________ Relationship to Patient ______________

Phone # ______________ Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

Emergency Contact (Please list TWO different contacts)

Primary Contact: ______________ Phone# ______________ Relation: ______________

Secondary Contact: ______________ Phone# ______________ Relation: ______________

Insurance Information (policy holder)

Name of Insured ______________________ Relationship to Patient ______________

Birthdate ______________ Social Security # ______________ ID# ______________

Name of Employer ______________________ Work Phone ______________

Insurance Company ______________ Group # ______________ Phone # ______________

Secondary Insurance

Name of Insured ______________________ Relationship to Patient ______________

Birthdate ______________ Social Security # ______________ ID# ______________

Name of Employer ______________________ Work Phone ______________

Insurance Company ______________ Group # ______________ Phone # ______________

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Patient Medical History

Physician ______________________**Office Phone**____________________ **Date of Last Exam** _________________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐

If yes, please explain ____

	Yes	No
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐

If yes, what medications are you taking? ____

	Yes	No
4. Are you currently taking or have you ever taken osteoporosis medications in the past?	☐	☐

If so, how long? ______________________________ Which ones? ___________________________________

	Yes	No
5. Any current use or history of use of tobacco?	☐	☐

If so, how long? ______________________________ What type and amount? ___________________________________

	Yes	No
6. Any current use or history of use of alcohol?	☐	☐

If so, how long? _________________ _ How frequent and amount? ___________________________________

	Yes	No
7. Do you use or have history of use of controlled substances or recreational drugs?	☐	☐

If yes, which ones (including medical marijuana) and how often? ____

8. **Are You Allergic to:**	**Yes**	**No**		**Yes**	**No**
Local Anesthetics (e.g. Novocain)	☐	☐	Iodine	☐	☐
Penicillin	☐	☐	Aspirin	☐	☐
Sulfa Drugs	☐	☐	Ibuprofen	☐	☐
Other Antibiotics ________________	☐	☐	Codeine	☐	☐
Latex Rubber	☐	☐	Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Sedatives	☐	☐	Other __________________________	☐	☐

9. **Women Only:**	**Yes**	**No**
a) Are you pregnant or think you may be pregnant?	☐	☐

When are you due? ____________ Who is your OB/GYN? _______________________ Phone# ____________________

	Yes	No
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

10. **Do you have or have you had any of the following?**

	Yes	**No**		**Yes**	**No**		**Yes**	**No**
High Blood Pressure	☐	☐	Seizures/Epilepsy	☐	☐	Anemia	☐	☐
Low Blood Pressure	☐	☐	Cancer	☐	☐	Emphysema/COPD	☐	☐
Heart Disease	☐	☐	Type ________________			Tuberculosis	☐	☐
Angina	☐	☐	Radiation Therapy	☐	☐	Asthma	☐	☐
Heart Attack	☐	☐	When _______________			Arthritis	☐	☐
When? ______________			Diabetes	☐	☐	Joint Replacement	☐	☐
Cardiac Pacemaker	☐	☐	Type ________________			When _______________		
Mitral Valve Prolapse	☐	☐	Kidney Diseases	☐	☐	Neck/Back Pain	☐	☐
Heart Murmur	☐	☐	Liver Disease	☐	☐	When _______________		
Congestive Heart Failure	☐	☐	Thyroid Problem	☐	☐	Glaucoma	☐	☐
Rheumatic Fever	☐	☐	Ulcers	☐	☐	Sight Impaired	☐	☐
Stroke	☐	☐	Hepatitis/Jaundice	☐	☐	Hearing Impaired	☐	☐
Vertigo	☐	☐	AIDS or HIV Infection	☐	☐	Hay Fever/Allergies	☐	☐
Fainting	☐	☐	STD's	☐	☐	Other _________________________		

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Patient Dental History

Name of Previous Dentist__________________________________ **Date of Last Exam/Cleaning** _______________

		Yes	No
1.	Do you like your smile? What would you change? ____	☐	☐1
2.	Do your gums bleed while brushing or flossing?	☐	☐2
3.	Are your teeth sensitive to hot or cold liquids/foods?	☐	☐3
4.	Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐4
5.	Do you feel pain on any of your teeth?	☐	☐5
6.	Do you have any sores or lumps in or near your mouth?	☐	☐6
7.	Have you had any head, neck or jaw injuries?	☐	☐7
8.	Have you ever experienced any of the following problems in your jaw?	☐	☐8
	A. Clicking	☐	☐A
	B. Pain (joint, ear, side of face)	☐	☐B
	C. Difficulty in opening or closing	☐	☐C
	D. Difficulty in chewing	☐	☐D
9.	Do you have frequent headaches or migraines?	☐	☐9
10.	Do you clench or grind your teeth?	☐	☐10
11.	Do you wear an Oral Appliance? ☐ CPAP ☐ Occlusal/Night guard ☐ Sports Guard		
12.	Have you ever been diagnosed with sleep apnea?	☐	☐12
13.	Do you snore?	☐	☐13
14.	Do you bite your lips or cheeks frequently?	☐	☐14
15.	Have you ever had any difficult extractions in the past?	☐	☐15
16.	Have you ever had any prolonged bleeding following extractions?	☐	☐16
17.	Have you had any orthodontic treatment?	☐	☐17
18.	Do you wear dentures or partials? If yes, date of placement____________________	☐	☐18
19.	Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐19

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I agree to be responsible for payment of all service rendered on my behalf of my dependents.

Print Name of Patient ______________________________ **Preferred Name** ___________________________

Signature of Patient (Parent of Minor) _____________________________________ **Date** __________________

Doctor's Signature ____ **Date** __________________

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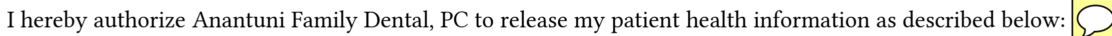
Office Policies

Notice of Privacy Practices & HIPAA

A laminated copy of our office Notice of Privacy Practices and HIPAA is available in our office. You have the right to read our Notice before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this consent. Upon your request we will be happy to provide you with your own personal copy of our Privacy Practices.

HIPAA regulations authorize the release of PHI for the purpose of treatment, obtaining payment from Third party payers, and the standard healthcare operations. Other than those releases authorized by HIPAA, PHI will only be released to persons listed on this authorization. If you choose not to authorize any family members or friends, we will not be able to release any information to anyone other than the patient.

I hereby authorize Anantuni Family Dental, PC to release my patient health information as described below:



Authorized Individual Name　　Relationship

Type of Information allowed to Disclose:　　**Type of Disclosure**:

☐ Dental Records ☐ Financial　　☐ Phone ☐ Person ☐ Email

I understand that I am not required to sign this authorization. I acknowledge that I have read or received a copy of this office's Notice of Privacy Practices and that Anantuni Family Dental abides by the HIPAA Law and will protect the privacy of my personal information.

Patient Name (Print)　　Signature or Patient or Guardian　　Date

Authorization for Signature on File

I (name of patient), ___________________________________ and/or (name of insured) ____, hereby authorize Anantuni Family Dental to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my insurer. I hereby authorize payment of dental benefits otherwise payable to me directly to the office above. I agree to be responsible for all charges for dental services whether or not paid by my insurance. I authorize the release of any information relating to this claim to obtain payment. I authorize the use of this signature on all insurance submissions.

Signature of Patient　　Date

This authorization will be valid from this date and shall expire in one year.

Financial Policy

Thank you for choosing Anantuni Family Dental to serve your dental care needs. We provide high-quality dental care to our patients and are committed to your treatment being successful. Please understand that your financial obligation is considered a part of your treatment. In the interest of good dental care practice, it is desirable to establish a credit policy to avoid misunderstandings. To assist our patients, we offer the following methods for taking care of their account in our office.

- On your first visit we expect you to supply our office with your insurance information and a photo ID. If any changes should occur during the time you are a patient, it is your responsibility to inform our office with any changes. Our office will not be responsible for claims submitted to insurance companies by which you are no longer covered.

- As a **courtesy**, we will gladly bill your insurance. While we accept most insurance plans, and are happy to aid in submission of your claims, it is your responsibility to read your policy and understand that this is a contract between your employer, your insurance company and yourself. Please be aware of some and perhaps all of the services rendered may be not covered by your individual plan and you are ultimately responsible for the payment on the account.

- We cannot accept responsibility for collecting an insurance claim after 60 days or for negotiating a disputed claim. If no payment is received on an account after two monthly statements our office will make every effort to contact the responsible party. If the party responsible cannot be reached, a third bill will be sent indicating that **"This will be the final notice for payment"**. If the party fails to contact our office after receiving such notice, the account will be sent to a collection agency.

- We ask that you either pay your estimated patient portion of the bill at the time of service, or that a suitable written financial arrangement be reached at the time of service. We accept cash, all major credit cards, personal checks, and financing from Care Credit, Lending Point and Lending Club. For all checks returned due to **non-sufficient funds**, there will be a $35 fee added to your account.

- If an insurance company pays more than anticipated creating a credit for the patient, we are happy to either refund the patient or leave the credit on the account to be applied toward future treatment.

- The original dental record, including but not limited to treatment notes, x-rays, study models are the property of Anantuni Family Dental. These originals will not be released to patients or other healthcare providers, without written request. I understand that a $25 fee may be applied to my account for duplication of my dental records and x-rays.

Delinquent Accounts

On occasion, after repeated attempts to collect a balance due, we may need to turn an account over to a collections agency. Should this occur, it is agreed that the financially responsible party listed below shall pay all finance charges, collection cost, attorney fees and any other costs that may be incurred to enforce collection of any amount outstanding. In addition, a collection fee based on the balance of the account will be added.

Failed or Cancelled Appointments

If an appointment has been reserved for you, we kindly ask that patients give us 48 ***busines*** hours notice for cancellations; otherwise, we reserve the right to charge a minimum of **$50 per hour** per scheduled appointment. If the appointment is with a specialist or longer than 1 hour, the minimum fee is **$75 an hour**. We will only offer appointments **SAME DAY** to patients who fail multiple appointments without having given us proper notice.

Scheduling Appointments

A deposit ($50 minimum) to secure a treatment appointment over 60 minutes will be collected at the time the appointment is made.

I confirm that I have read and understand this form or it was read to me and all of my questions have been answered to my satisfaction.

Patient Name Signature of Patient or Guardian Date

Photography Release

I, ______________________________, do hereby authorize and consent to the use of certain digital photographs and/or diagnostic x-rays of me taken by Anantuni Family Dental. I hereby grant permission to reproduce, publish, print, use and distribute copies of such photographs/x-rays either in an official medical publication or in lectures for educational purposes. I further grant permission for my digital photos and diagnostic x-rays to be used on our practice social media for educational purposes.

NO full face or identifying photos will be used without your expressed written consent

Please note that digital photography taken during treatment is used by our laboratories for cosmetic purposes in the fabrication of crowns, bridges, veneers, dentures and orthodontics. These images will be retained as a part of your treatment dental record.

Please initial one of the following:

____ I **do not consent** to the use of digital photos or x-rays for use in dental education or publications. These records are strictly for use in my plan of care.

____ I **do consent** to the use of digital photos **(full face)** or x-rays for use in dental education and/or publications including Anantuni Family Dental social media.

____ I **do consent** to the use of digital photos **(no full face)** or x-rays for use in dental education and /or publications including Anantuni Family Dental social media.

I further acknowledge that my participation is voluntary and that I will not receive financial compensation of any type associated with the taking or publication of these photographs or participation in company marketing materials or other dental office publications. I acknowledge and agree that publication of photographs confers no rights of ownership or royalties whatsoever.

____

Print Name | Signature | Date

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