NORTHERN ARIZONA PERIODONTICS
Dental Implants & Specialized Gum Care

COTTONWOOD
657 E Cottonwood Street, Suite 1
Cottonwood AZ, 86326
928 634 5033

WEST SEDONA
1146 W State Route 89A, Suite C3
Sedona AZ, 86336
928 282 2946

First Name (check one☐Mr.☐Mrs.☐Ms.☐Dr.) | Middle Initial | Last Name | Preferred Name

Mailing Address | City | State | Zip Code

E-Mail Address | Main Phone | Cell Phone

Social Security Number | Birth Date | General Dentist's Name

Preferred Pharmacy | Pharmacy Address

Person Responsible for Account (if different) | Relationship | Phone Number | Birth Date

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 Practice at Northern Arizona Periodontics, with any member of our office staff.

Emergency Contact Name | Relationship | Emergency Contact's Phone Number

Emergency Contact Name | Relationship | Emergency Contact's Phone Number

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	☐ Convulsions	☐ Heart Pacemaker	☐ Recent Weight Loss/Gain
☐ Alzheimer's/Dementia	☐ Cortisone Medicine	☐ Heart Trouble/Disease	☐ Renal Dialysis
☐ Anemia	☐ Diabetes: A1C _____	☐ Hemophilia	☐ Rheumatic Fever
☐ Angina	☐ Diabetes: Family History	☐ Hepatitis _____	☐ Scarlet Fever
☐ Arthritis/Gout	☐ Drug Addiction / Use	☐ High Blood Pressure	☐ Shingles
☐ Artificial Heart Valve	☐ Elevated Cholesterol	☐ Hives / Rash	☐ Sickle Cell Disease
☐ Artificial Joint	☐ Emphysema	☐ Irregular Heartbeat	☐ Sinus Trouble/Infection
☐ Asthma	☐ Epilepsy or Seizures	☐ Kidney Problems	☐ Sleep Apnea-CPAP? ___
☐ Blood Disease	☐ Excessive Bleeding	☐ Leukemia	☐ Sores/Growth in Mouth
☐ Blood Transfusion	☐ Fainting/Dizziness Spells	☐ Liver Disease	☐ Stroke _____
☐ Bruise Easily	☐ Frequent Headaches	☐ Low Blood Pressure	☐ Thyroid Disease
☐ Cancer _____	☐ Gastric Bypass Surgery	☐ Lung Disease	☐ Tuberculosis
☐ Chemotherapy / Radiation	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tumors or Growths
☐ Chest Pains	☐ Hay Fever	☐ Osteoporosis/Osteopenia	☐ Ulcers
☐ Cold Sores/Fever Blisters	☐ Heart Attack _____	☐ Parathyroid Disease	☐ Other _____
☐ Congenital Heart Disease	☐ Heart Murmur	☐ Psychiatric Care	☐ **None**

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) ☐ Other _____

☐ Aspirin	☐ Darvon	☐ Latex	☐ Nitrous Oxide	☐ Percodan	☐ Tetracycline
☐ Codeine	☐ Erythromycin	☐ Local Anesthetic	☐ Penicillin / Amoxicillin	☐ Sulfa	☐ Valium

Have you EVER taken any the following medications? ☐ **No** ☐ **Yes** (✓ all that apply, circle **P-Past**, **C-Current**, & list **duration**)

Blood Thinners: Typical INR: ____

- ☐ Coumadin: P☐ C☐ _____
- ☐ Eliquis: P☐ C☐ _____
- ☐ Ibuprofen: P☐ C☐ _____
- ☐ NSAIDs: P☐ C☐ _____
- ☐ Paradaxa: P☐ C☐ _____
- ☐ Xarelto: P☐ C☐ _____
- ☐ Zometa: P☐ C☐ _____

Bisphosphonates:

- ☐ Actonel: P ☐C☐ _____
- ☐ Alentronate (Fosamax): P☐C☐ _____
- ☐ Aredia: P ☐C☐ _____
- ☐ Boniva: P ☐C☐ _____
- ☐ Reclast: P ☐C☐ _____
- ☐ Risedronate (Actonel): P☐ C☐ _____

Other:

- ☐ Herbal Supplements: P☐ C☐ _____

Tobacco Use: ☐ Never ☐ Quit: Year _____ ☐ Nicotine Vape ☐ Chew Tobacco ☐ Cigarettes/Cigars _____ /day

Present Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Unsure

Are you under a physician's care? ☐ No ☐ Yes, explain: _____

Any changes in general health in the past year? ☐ 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

For an accurate insurance estimation, please complete this section as much as you can.

Primary Dental Insurance

Subscriber Name	Subscriber Date of Birth	Subscriber Number	Relationship

Insurance Company Name	Group Number	Insurance Phone Number	Subscriber Employer

Secondary Dental Insurance

Subscriber Name	Subscriber Date of Birth	Subscriber Number	Relationship

Insurance Company Name	Group Number	Insurance Phone Number	Subscriber Employer

OFFICE POLICIES

Thank you for choosing **Northern Arizona Periodontics** to serve your periodontal needs. We are committed to providing you with the highest quality dental care, so that you may attain optimum oral health. The following is a statement of our Payment, Insurance, Cancelation, Fee Guarantee, Communication, and Privacy Practice policies, which we require that you read and sign prior to any treatment.

Payment Policy: I understand that 50% of the estimated patient portion is required upon scheduling of treatment. **The other 50%, payment in full, is required 48 hours prior to my scheduled appointment to avoid cancellation**. After an insurance claim is finalized, any remaining balance over 90 days may accrue service charges. Any finance, late, re-billing, collection charge, and/or attorney fee will be added to any overdue balance and must be paid by me.

Insurance Policy: I understand that the office is contracted as a Delta Dental PPO Provider only, and that as a courtesy, Northern Arizona Periodontics, will submit all dental insurance claims, on **my** behalf, for **up to two** insurance providers. I understand that insurance estimates are a best guess based on information my insurance company provided, does not include recent dental claims from other offices, and is not a guarantee that my insurance will pay exactly as estimated. Under no circumstances will any insurance company guarantee payment prior to treatment. **I am responsible for any and all costs that will not be covered by my insurance plan.**

Insurance Claims: I authorize my insurance company to pay my dental dental benefits.

Cancelation Policy: I understand that 48-business hour notification is required for any and all appointment cancellations, otherwise a cancellation fee of $75 may be assessed to my account. Leaving a message does not qualify as notification. Unusual circumstances will be considered on a case-by-case basis.

Fee Guaranteed Policy: I understand fees on my treatment plan will be valid for **90 days following the printed date of my treatment plan**. Beyond the 90 days, my treatment plan may be subject to increases/decreases in fees and may no longer qualify for any discounts given.

Medicare Policy: I understand that Northern Arizona Periodontics has opted out of Medicare and is not contracted with nor is a provider for Medicare.

Privacy Practices Policy: By signing below, I acknowledge that I received a copy of the Notice of Privacy Practices.

☐ **I refused to acknowledge the Notice of Privacy Practices**

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.**

Patient OR Patient's Legal Representative's Signature	Relationship

Patient Name (please print)	Birth Date	Today's Date