PRECISION DENTAL
GENERAL & COSMETIC DENTISTRY

Child Dental Registration & Treatment

Patient Information

Patient Name_____

Date of Birth_____ ☐ Male ☐ Female

Address _____

_____

_____

Home Phone_____

School_____

Patient Lives:

☐ With Both Parents ☐ With Father

☐ With Mother ☐ Other_____

Guardian/Parent Information

Parent/Guardian Name:_____

Date of Birth _____SS/ID#_____

Home Phone _____Work_____

Cell Phone_____

E-mail _____

May we use your email and/or mobile number to send appointment reminders, confirm appointments or other information regarding your child's dental care?

☐ Yes ☐ No

Emergency Contact

Name _____

Relationship to Patient _____

Home Phone _____Cell Phone _____

How did you hear about Precision Dental?

☐ Referral (Their Name)_____

☐ Mailing ☐ Social Media (Facebook, Instargram etc)

☐ Building Sign ☐ Insurance Company

☐ Our Website ☐ Online Review (Yelp, Google, Demand Force)

☐ Other _____

Primary Dental Insurance

Subscriber Name _____

Relationship to Patient _____

Date of Birth _____ SS/ID# _____

Address (if different from patient) _____

_____

_____

Subscriber's Employer _____

Insurance Company _____

Group # _____

Secondary Dental Insurance

Subscriber Name _____

Relationship to Patient _____

Date of Birth _____ SS/ID# _____

Address (if different from patient) _____

_____

_____

Subscriber's Employer _____

Insurance Company _____

Group # _____

Assignment and Release

I certify that I, and/or my dependant(s), have insurance coverage with _____ and assign directly to Precision Dental
(Name of Insurance Company)
and it's associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Precision Dental and its associates may use my health care information and may disclose such information to the above named company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

Signature of Guardian or personal representative _____

Print name of Guardian or personal representative _____

Relationship to patient _____

Date _____

PRECISION DENTAL
GENERAL & COSMETIC DENTISTRY

Dental & Medical History Information

Dental History

Patient Name _____ Reason for today's visit _____

Former Dentist _____ City/State _____

Date of last dental visit_____ Date of last dental X-rays _____ How often do you brush? _____ Floss? _____

Please check all dental conditions that apply, past or present:

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Blisters on lips or mouth
- ☐ Burning sensation on tongue
- ☐ Chew on one side of mouth
- ☐ Cigarette/pipe/cigar smoking
- ☐ Clicking or popping jaw
- ☐ Dry mouth
- ☐ Fingernail biting
- ☐ Food collection between teeth
- ☐ Foreign objects
- ☐ Grinding teeth
- ☐ Gums swollen or tender
- ☐ Jaw pain
- ☐ Jaw tiredness
- ☐ Lip or cheek biting
- ☐ Loose teeth/broken filling(s)
- ☐ Mouth breathing
- ☐ Mouth pain, brushing
- ☐ Orthodontic treatment
- ☐ Pain around ear
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores/growths in mouth

Medical History

Physician's Name _____ City/Phone# _____/(___)___-_____ Date of last visit _____

Please check all that apply:

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Joints
- ☐ Asthma, Use Inhaler: ☐ Yes ☐ No
- ☐ Blood Disease
- ☐ Cancer, Type _____
- ☐ Chemical Dependency
- ☐ Chemotherapy, when _____
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, persistent/bloody
- ☐ Diabetes
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis, type ____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Weight Loss/Gain
- ☐ Radiation Therapy, when_____
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Special Diet
- ☐ Stroke
- ☐ Swollen Feet/Ankles
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor on Head/Neck
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Other _____

Have you ever taken a medication that contains bisphosphonates? This includes brands such as Actonel, Aredia, Boniva, Didronel, Fosamax, Zometa. ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Medications (List any medications you are currently taking and the correlating diagnosis):

_____

Allergies (Please check all that apply):

☐ Aspirin ☐ Codeine ☐ Erythromycin ☐ Latex ☐ Local Anesthetic ☐ Metals ☐ Penicillin ☐ Sulfa ☐ Tetracycline ☐ Other_____

I certify to the accuracy of the above statements regarding my medical and dental history

_____ Signature of patient, parent guardian or representative

_____ Print name of patient, parent guardian or representative

_____ Date

PRECISION DENTAL
GENERAL & COSMETIC DENTISTRY

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgment
If the patient is under 18 years of age, a parent or legal guardian must sign.

I, _____, have received a copy of this office's Notice of Privacy Practices.
{Please Print Patients Name}

_____
{Signature of Patient or Parent/Legal Guardian}

_____
{Date}

For Patients who need pre-medication only:
I am authorizing this office to call me and remind me to take my pre-medication before my dental appointment. They may leave a message for me regarding this information at any number that I have supplied to them. They may leave a message on any answering machine, voice mailbox or with whoever answers the telephone. I also authorize this office to remind me of my pre-medication on any postcard reminders that the office will mail to me.

_____
{Signature of Patient or Parent/Legal Guardian}

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Patient reviewed Privacy Practices but elected not to take a copy home
- ☐ Other (Please Specify)

Employee signature: _____ Date: _____

3885 S Val Vista Dr. Ste. 106 Gilbert, AZ 85297 480-899-8999

PRECISION DENTAL
GENERAL & COSMETIC DENTISTRY

Financial Policy

We want to avoid any misunderstanding about our financial policy as it relates to your responsibilities for your account. Please read the following information and address our staff with any questions.

1. If you have dental insurance, our dental staff will be glad to help you obtain the appropriate dental benefits from your insurance carrier and bill your carrier as a courtesy. However, you are ultimately responsible for the fees associated with your dental care. Please keep in mind that the contractual arrangement is between you and your insurance company; Precision Dental is a 3rd party provider responsible only for the delivery of your dental services.
2. We accept cash, personal check, money order, cashier's check and credit cards (Visa, Discover, MasterCard, and American Express), as well as Care Credit credit services.
3. Portions of your bill may not be paid by the insurance carrier and must be paid by you. Any insurance deductible or co-payment required by your insurance carrier **is due at the time services are rendered.**
4. If you do not have insurance coverage or if you have a discount policy,payment is due at the time services are rendered unless other financial arrangements have been made prior to your appointment.
5. If your treatment plan requires a high out-of-pocket expense, our office manger can assist you in arranging financing or a payment schedule, upon approval.
6. If you fail to keep your scheduled appointment or cancel your appointment without 24 hours notice, your account will be charge a $35 broken appointment charge for each hour of time that was reserved for your services.

Additional Terms

1. Balances unpaid after 30 days from the date of billing are subject to a finance charge at a rate of 3% per month (37% per annum).
2. Accounts referred to a collection agency will have collection costs added in the amount of 30% of the outstanding balance, together with court costs and reasonable attorney's fees.

Thank you for taking the time to familiarize yourself with our financial policy.

I acknowledge that I have read the above information and have been provided with an opportunity to ask questions about its content. I accept full financial obligation for the services that I agree to receive by the dental professionals at Precision Dental.

Patient Name:_____ Date:_____

Patient or Guardian Signature:_____

3885 S Val Vista Dr. Ste. 106 Gilbert, AZ 85297 480-899-8999