PATIENT INFORMATION

First Name_____ MI____ Last Name_____
❑ Male ❑ Female

Preferred Name _____ Date of Birth ___/___/___ Age_____ SSN#_____
❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Partner ❑ Child

Address_____

ZIP _____ City_____ State_____

Home # (_____)_____ Cell # (_____)_____ Work# (_____)_____
PRIMARY CONTACT PHONE # ❑ Home ❑ Cell ❑ Work

Email Address: _____@_____

Name of Your Employer _____

WHO MAY WE THANK FOR REFERRING YOU? _____

DENTAL INSURANCE

PRIMARY INSURANCE COVERAGE

Subscriber Name_____ Subscriber Date of Birth ____/____/____

Subscriber Employer_____ Subscriber SSN# ____/____/____

Relationship To Patient ❑ Self ❑ Spouse ❑Parent ❑ Other Subscriber ID# _____

Dental Ins. Co. _____ Ins. Phone # (____)_____

Ins. Co. Address _____City_____State____Zip_____

Effective Date____/____/____ Group # _____

SECONDARY INSURANCE COVERAGE

Subscriber Name_____ Subscriber Date of Birth ____/____/____

Subscriber Employer_____ Subscriber SSN# ____/____/____

Relationship To Patient ❑ Self ❑ Spouse ❑Parent ❑ Other Subscriber ID#_____

Dental Ins. Co. _____ Ins. Phone # (____)_____

Ins. Co. Address _____City_____State____Zip_____

Effective Date____/____/____ Group # _____

Please Turn Page Over To Complete This Form

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name _____ Relation to Patient _____

Address _____ Zip _____ City _____ ST____

Home # (____) _____ Cell # (____) _____ Work # (____) _____

Date of Birth ____/____/____ Age ____ SSN# _____-_____-_____ Drivers Lic#_____

Other Family Members That Are Patients In This Office: _____

Name of Your Employer _____

EMERGENCY CONTACT _____ Ph# (____)_____ Relation _____

EMERGENCY CONTACT _____ Ph# (____)_____ Relation _____

SPOUSE'S INFORMATION

Spouse's Name _____ Relation to Patient _____

Address _____ Zip _____ City _____ ST____

Home # (____) _____ Cell # (____) _____ Work # (____) _____

Date of Birth ____/____/____ Age ____ SSN# _____-_____-_____ Drivers Lic# _____

Spouse's Employer _____

Please check appropriate box below, sign & print your name with today's current date.

- ❑ Patient
- ❑ Parent
- ❑ Guardian

SIGNATURE X_____ Date _____

X_____

(Please Print Your Name Above)

MEDICAL HISTORY

PATIENT NAME: _____

DO YOU CURRENTLY HAVE OR HAVE YOU EVER BEEN TREATED FOR:
Please Check *Y for Yes* & *N FOR No* in each space below. ***Do not omit any responses.***

Y__ N__ Heart Murmur
Y__ N__ Rheumatic Fever
Y__ N__ Mitral Valve Prolapse
Y__ N__ Prosthetic Heart Valve
Y__ N__ Pacemaker
Y__ N__ Endocarditis
Y__ N__ Angina
Y__ N__ Arrthymia
Y__ N__ Other Heart Problems
Y__ N__ High Blood Pressure
Y__ N__ Low Blood Pressure
Y__ N__ Stroke / TIA
Y__ N__ Aneurysm / Blood Clots

Y__ N__ Thyroid Condition
Y__ N__ Tuberculosis
Y__ N__ Asthma / Respiratory Conditions
Y__ N__ Emphysema
Y__ N__ Stomach Ulcers / Reflux
Y__ N__ Fibromyalgia / Lupus

Y__ N__ HIV / AIDS
Y__ N__ Hepatitis A/B/C
Y__ N__ Herpes

Y__ N__ Joint Replacement (Knee, Hip, Etc)
Y__ N__ Screw, Rod, Metal Plate Placement
Y__ N__ Diabetes
Y__ N__ Hemophelia / VonWillerbrands Disease
Y__ N__ Bleeding / Bruising
Y__ N__ Anemia / Sickle Cell Disease
Y__ N__ Cancer / Tumors
Y__ N__ Radiation / Chemotherapy
Y__ N__ Cigarette / Cigar / Pipe Smoker

Y__ N__ Fainting
Y__ N__ Epilepsy / Convulsions
Y__ N__ Anxiety
Y__ N__ Depression
Y__ N__ Bipolar Disorder
Y__ N__ ADHD / ADD
Y__ N__ Migraine Headaches
Y__ N__ Alcohol Abuse
Y__ N__ Substance Abuse

Y__ N__ Liver Disease
Y__ N__ Kidney Disease
Y__ N__ Dialysis

Allergies or Sensitivities
Y__ N__ Latex
Y__ N__ Penicillin
Y__ N__ Tetracycline
Y__ N__ Erythromycin
Y__ N__ Clindamycin
Y__ N__ Sulfa Drugs
Y__ N__ Codeine
Y__ N__ Ibuprofin
Y__ N__ Aspirin
Y__ N__ Acetaminophen / Tylenol
Y__ N__ Metals
Y__ N__ Anesthetics
Y__ N__ Any Other Medications

Are You Taking Any of the Following
Y__ N__ Aspirin on a daily basis
Y__ N__ Coumadin, Warfarin, Plavix
Y__ N__ Birth Control Pills (Women)
Y__ N__ Ever taken Fosamax, Actonel, Boniva, Zometa, Reclast

Y__ N__ Hospitalization / Surgery last 5 yrs
Y__ N__ Currently Pregnant / Nursing

DENTAL HISTORY

Y__ N__ Would you like non-silver fillings
Y__ N__ Bleeding Gums
Y__ N__ Bad Breath

Y__ N__ Aching or Popping Jaws
Y__ N__ Prior TMJ Therapy
Y__ N__ Grinding/Clenching Your Teeth

Y__ N__ Frequent Headaches
Y__ N__ Loose Teeth
Y__ N__ Prior Gum Treatment

How Often Do You Brush? _____ ***How Often Do You Floss?*** _____
Last Dental Visit _____ ***Reason For Today's Visit*** _____

Your Physician's Name _____ **Phone #** _____
Date of Last Physical _____ **Results** _____
Patient's Height _____ **Patient's Weight** _____

Please List ALL MEDICATIONS or HERBS which you are on

Name & Purpose

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Please List Any OTHER CONDITIONS Not Addressed Above

_____

_____

I Hereby certify that the information provided above is true and accurate statement of my medical condition. I further give my consent and authorization to receive prescribed dental treatment and local anesthesia in accordance with laws of the State of Arizona.

X_____ _____ _____ _____
Signature of Patient/Parent/Guardian DATE Signature of Dentist DATE

NORTH MOUNTAIN DENTISTRY
JUSTIN JONES DMD

FINANCIAL POLICY

We have many requests asking what our office policy is with regard to insurance and the extension of credit, so we would like to explain some of this policy to you in advance because your understanding and cooperation are so important.

SELF PAY

For those of our patients who do not have insurance coverage, fees are due and payable at the time of service. If you anticipate any problems with this, please contact the business office prior to any treatment.

INSURANCE

As a courtesy to our patients, we would be most happy to submit insurance for treatment provided that:

1) Proof of insurance is provided.
2) The estimated portion not covered by insurance is paid at the time services are rendered. We will then bill your insurance carrier and set aside that portion of the balance to be paid by them for 60 days. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. Since we are not a party to the agreement with your insurance company, it is not our policy to contact carriers to establish why they haven't paid, or why they paid less then originally indicated.

MONTHLY STATEMENTS

You will continue to receive regular monthly statements regardless of anticipated insurance payments. It would be advisable for you to follow up with your insurance carrier if payment exceeds the 60-day limit. A finance charge of 1.5% per month will be added to all unpaid balances after 60 days.

EXTENDED PAYMENT PLANS

Payment Plans are available to patients with approved credit on larger cases. Please inquire at the reception desk. If you have any questions about any office policies or procedures, we will be pleased to discuss them with you. We value you, our patient, and will continue to provide you with our best professional care.

CANCELLATION POLICY

We do require a 24-hour notice for cancellation of appointments. Less than 24-hour notice may result in a minimum $60.00 fee.

PATIENT SIGNATURE_____ **DATE**_____