



Patient Information

Skip Form

First Name *

Last Name *

MI

Preferred Name

Title

Gender *

Family Status *

Birthday *

MM / DD / YYYY

SSN

Drivers license

Address *

Street Address

Address Line 2 (Apartment number, Suite number, or Room number)

City

Select a State/Province

State / Province / Region

United States

Postal / Zip Code

Country

Home Phone

- -

Work Phone

- -

Mobile Phone

- -

Email *

Referred By

Student Status

School Name

Employment Status *

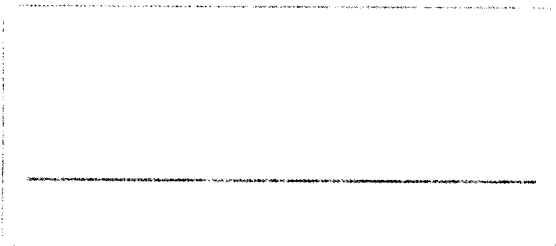
Appointment Preference

Communication Preferences

☐ I receive emails

☐ I receive mobile text

Draw your signature into the box below. *



Clear

Relationship to the patient *

Name if not the patient *

Continue



Eaglesoft Medical History

Skip Form

Patient First Name

Patient Last Name

Do you have, or have you had, any of the following?

- | | | |
|--|---|--|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Anaphylaxis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Angina | <input type="checkbox"/> Arthritis/Gout |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Breathing Problems |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Congenital Heart Disorder |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Excessive Thirst |
| <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Frequent Diarrhea |
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Hives or Rash |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Renal Dialysis |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Shingles | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> Stomach/Intestinal Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Swelling of Limbs | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors or Growths | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Yellow Jaundice | |

Have you ever had any serious illness not listed above? *

☐ No ☐ Yes

☐ Venereal Disease

☐ Yellow Jaundice

Have you ever had any serious illness not listed above?

☐ No ☐ Yes

Are you under a physician's care now?

☐ No ☐ Yes

Have you ever been hospitalized or had a major operation?

☐ No ☐ Yes

If yes, please explain

Have you ever had a serious head or neck injury?

☐ No ☐ Yes

Are you taking any medications, pills, or drugs?

☐ No ☐ Yes

If yes, please explain

Do you take, or have you taken, Phen-Fen or Redux?

☐ No ☐ Yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?

☐ No ☐ Yes

Are you on a special diet?

☐ No ☐ Yes

Do you use tobacco?

☐ No ☐ Yes

Do you use controlled substances?

☐ No ☐ Yes

Women: Are you...

☐ Pregnant/Trying to get pregnant?

☐ Nursing?

☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin

☐ Penicillin

☐ Codeine

☐ Acrylic

☐ Metal

☐ Latex

☐ Sulfa Drugs

☐ Local Anesthetics

Other?

☐ No ☐ Yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Draw your signature into the box below.

Continue

Scottsdale Dentist



HIPAA Acknowledgement Form

Skip Form

Patient First Name *

Patient Last Name *

Relationship to the patient *

Name if not the patient *

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

-Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly

-Obtain payment from designated third-party payers.

-Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

I have been informed by you of your Notice of Privacy Practices that contains a more complete description of the uses and disclosures of my health information (available at the following link [HIPAA Notice of Privacy Practices](#) or in office in print form).

I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that Scottsdales Dentist has the right to change its Notice of Privacy Practices from time to time and that I may contact Scottsdales Dentist at any time to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that Scottsdales Dentist restricts how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand Scottsdales Dentist is not required to agree to my requested restrictions, but if Scottsdales Dentist does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that Scottsdales Dentist has taken action relying on this consent.

By checking the box I acknowledge that *

☐ I received and read this organization Notice of Privacy Practices

Please sign *

Clear

Continue

Scottsdales Dentist



Dental History

[Skip Form](#)

Patient First Name

Patient Last Name

Dental History Adult

Why are you changing your dentist?

How long ago was your last visit to your dentist? *



Name of previous dentist

How did you find us? *



Reason for today's visit:

☐ Check-up

☐ Cleaning

☐ Pain

☐ Other

Provide details

Have you ever had a bad experience at the dentist? *

☐ No ☐ Yes

Have you had any complications following treatment? *

☐ No ☐ Yes

Have you had any unfavorable reactions to dental anesthetic? *

☐ No ☐ Yes

Does dental treatment make you nervous? *



Are your teeth sensitive to cold or hot temperatures? *

☐ No ☐ Yes

Do your gums bleed when you brush or floss? *

☐ No ☐ Yes

Do you grind your teeth? *

☐ No ☐ Yes

Are you aware of sores or irritated areas in the mouth? *

☐ No ☐ Yes

Have you ever been treated for Periodontal Disease? *

☐ No ☐ Yes

Have you ever had orthodontic treatment?

☐ No ☐ Yes

Have you ever been told to premedicate prior to your dental appointment?

☐ No ☐ Yes

How often do you brush? *



How often do you floss? *



Do you like your smile? *

☐ No ☐ Yes

If you could change your smile, what would you like to change?

- | | |
|---|---|
| <input type="checkbox"/> Change the color of my teeth | <input type="checkbox"/> Close spaces or restore worn out or broken teeth |
| <input type="checkbox"/> Change the shape of my teeth | <input type="checkbox"/> Change the position or alignment of my teeth |
| <input type="checkbox"/> Other | |

I am interested in

- | | | |
|--|--|---|
| <input type="checkbox"/> Teeth whitening | <input type="checkbox"/> Cosmetic evaluation | <input type="checkbox"/> Replacement of missing teeth |
| <input type="checkbox"/> Straight teeth | <input type="checkbox"/> Sedation | <input type="checkbox"/> White fillings |
| <input type="checkbox"/> Home care | <input type="checkbox"/> Breath control | <input type="checkbox"/> Other |

To ensure your visit is a great experience, please share any questions or concerns you would like us to know about:

In the event we need to call in a prescription for you, please provide the following pharmacy information:

Pharmacy Name

Pharmacy Phone Number

Pharmacy Address

Records Release

Patient Name

Date of Birth

Please receive my dental records from:

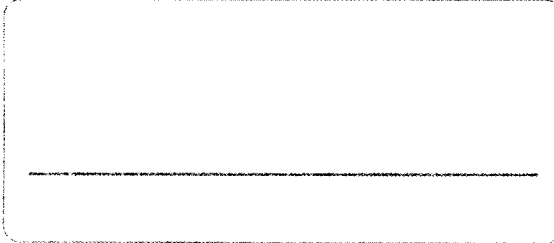
Dentist Name

Phone Number

Address

Email *

Draw your signature into the box below. *

A rectangular box with a dashed border, intended for drawing a signature. A horizontal line is visible near the bottom of the box.

Clear

Relationship to the patient *



Name if not the patient *

Please email the above name patient's records to:

Scottsdalesdentist@gmail.com (480) 948-1720

Continue



Dental Insurance Information

Please note that if you don't have dental insurance simply enter patient's first and last name, check the box "I don't have dental insurance", and click "Continue" button

Skip Form

Page 1 of 5 - Responsible Party

20%

Patient First Name *

Patient Last Name *

☐ I don't have dental insurance

If patient is responsible party please check the box below and go to the next page

☐ The patient is responsible party

Responsible Party First Name

Responsible Party Last Name

Birth Date

/ /
MM DD YYYY

Gender

☐ Male ☐ Female

Social Security Number

Address

Street Address

Address Line 2 (Apartment number, Suite number, or Room number)

City

Select a State/Province

State / Province / Region

United States

Postal / Zip Code

Country

Home Phone Number

Form for Home Phone Number input, consisting of three boxes separated by dashes.

Mobile Phone Number

Form for Mobile Phone Number input, consisting of three boxes separated by dashes.

Work Phone Number

Form for Work Phone Number input, consisting of three boxes separated by dashes.

Relationship to Patient

- ☐ Spouse
- ☐ Parent
- ☐ Other

Form for Other relationship input, consisting of a single box.

Continue

Scottsdales Dentist