Scottsdales Dentist

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

Scottsdales Dentist

Eaglesoft Medical History

Skip Form

Patient First Name

Patient Last Name

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

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

C No O Yes

Are you under a physician's care now?

C No O Yes

Have you ever been hospitalized or had a major operation?

O No O Yes

If yes, please explain

Have you ever had a serious head or neck injury?

O No O Yes

Are you taking any medications, pills, or drugs?

O No O Yes

If yes, please explain

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

O No O Yes

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

O No O Yes

Are you on a special diet?

O No O Yes

Do you use tobacco?

O No O Yes

Do you use controlled substances?

O No O 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?

O No O 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

Scottsdales Dentist

Scottsdales 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

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 treament 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?

- ☐ Change the color of my teeth
- ☐ Close spaces or restore worn out or broken teeth
- ☐ Change the shape of my teeth
- ☐ Change the position or alignment of my teeth
- ☐ Other

I am interested in

- ☐ Teeth whitening
- ☐ Cosmetic evaluation
- ☐ Replacement of missing teeth
- ☐ Straight teeth
- ☐ Sedation
- ☐ White fillings
- ☐ Home care
- ☐ Breath control
- ☐ 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. *

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

Scottsdales Dentist

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

- -

Mobile Phone Number

- -

Work Phone Number

- -

Relationship to Patient

- ○ Spouse
- ○ Parent
- ○ Other

Continue

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