SCOTTSDALE SMILE CENTER
5410 North Scottsdale Road, Suite D-500 | Paradise Valley, Arizona 85253
(480) 991-2180 | staff@scottsdalesmile.com | scottsdalesmile.com

PATIENT INFORMATION

Name: _____ Nickname: _____

Male ○ Female ○ Date of birth: _____ Social Security Number: _____

Home Address: _____

Phone: _____ E-mail Address: _____

Employer: _____ Occupation: _____

How do you prefer to confirm your appointment? Phone call ○ Email ○ Text message ○

Previous Dentist: _____ Phone Number: _____

Date of last visit _____ Who may we thank for referring you? _____

Primary Dental Insurance

Insurance Company Name: _____ Policy Holder Name: _____

Address: _____ Relation: _____

Phone: _____ Policy Holder Date of Birth: _____

Member ID: _____ Policy Holder Social Security Number _____

FINANCIAL POLICY

Our Patient-Centric Approach

At Scottsdale Smile Center, our focus is providing high-quality care that is based on your specific needs, risk factors, and treatment goals. While we understand and respect that insurance benefits are important to many patients, we firmly believe that treatment decisions should stay between you and your doctor, without allowing dental benefits to influence our ethical, tailored approach to providing patient care.

Dental Insurance and Financial Policy

Accordingly, we are not contracted with any insurance companies and are therefore considered an "out-of-network," practice. This means that you can still use your insurance benefits, but that you will be individually responsible for the remaining portion of our fees not paid by insurance, within 60 days.

Although we are not contracted with any insurance companies, as a courtesy to our patients, we are happy to process and submit insurance claims on your behalf. While we do our best to provide our patients with the most accurate estimates of their dental coverages, we cannot guarantee what coverages, if any, your insurance company will provide. You are ultimately responsible for covering all fees associated with the treatment(s) you receive and ask that you please familiarize yourself with the specifics of your insurance company.

Appointment Commitment

If you are unable to keep your appointment, please contact us at least 48 hours in advance to cancel or reschedule. Any missed appointment may incur a fee of $50 for each appointment hour.

Patient (print name) _____ Patient Signature _____ Date _____

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HEALTH HISTORY

Name _____ Date of birth _____

List all medications you are currently taking, including supplements and oral contraceptives.

_____

_____

Name of Primary Care Physician: _____

Do you take antibiotics before dental treatment? ☐ No ☐ Yes

If yes, please specify which medication and why _____

Health History (please check all that apply)

Do you take medication for or have high blood pressure? ☐ No ☐ Yes

BP Today _____

Diabetes: Type I ☐ Type II ☐ None ☐

Last A1C: _____ Approx. date: _____

Are you taking blood thinners? ☐ No ☐ Yes

Please specify reason (e.g. stroke) _____

ADD/ADHD	☐ No	☐ Yes
Anxiety/Depression	☐ No	☐ Yes
Anemia	☐ No	☐ Yes
Arthritis	☐ No	☐ Yes
Asthma	☐ No	☐ Yes
Autoimmune Disease/Rheumatism	☐ No	☐ Yes

Please Specify _____

Cancer ☐ No ☐ Yes

Please specify type and date _____

Are you currently receiving or have you ever received radiation? ☐ No ☐ Yes

Congenital Heart Disease	☐ No	☐ Yes
COPD	☐ No	☐ Yes
Dementia	☐ No	☐ Yes
Epilepsy	☐ No	☐ Yes
Fainting or Dizzy Spell	☐ No	☐ Yes
Frequent Headaches	☐ No	☐ Yes
Gastric Reflux	☐ No	☐ Yes
Glaucoma	☐ No	☐ Yes
Heart Attack	☐ No	☐ Yes

Please specify date _____

Heart Valve (replacement or repair)	☐ No	☐ Yes
Hepatitis	☐ No	☐ Yes

Please specify type _____

Herpes: Oral ☐ Genital ☐	☐ No	☐ Yes
HIV/AIDS	☐ No	☐ Yes
Hypo/Hyperthyroidism	☐ No	☐ Yes
Joint Replacement?	☐ No	☐ Yes

Please specify type _____

Kidney Disease	☐ No	☐ Yes
Liver Disease	☐ No	☐ Yes
Muscle/Connective Tissue Disorder	☐ No	☐ Yes
Osteoporosis/Osteopenia	☐ No	☐ Yes
Have you ever taken bisphosphonates?	☐ No	☐ Yes
Are you pregnant? Which trimester? _____	☐ No	☐ Yes
Previous Endocarditis/Rheumatic Fever	☐ No	☐ Yes
Sleep Apnea/Snoring/Insomnia	☐ No	☐ Yes
Stroke (type and date: _____)	☐ No	☐ Yes

Allergies

Aspirin, Ibuprofen, or any other NSAIDs	☐ No	☐ Yes
Latex	☐ No	☐ Yes
Local Anesthetics	☐ No	☐ Yes
Penicillin or other Antibiotics	☐ No	☐ Yes
Other	☐ No	☐ Yes

Please Specify _____

Tobacco, Alcohol, Drugs

Do you smoke, vape, or chew tobacco products?	☐ No	☐ Yes
Do you consume alcohol?	☐ No	☐ Yes

How much/often? _____

Do you use any mood-altering or recreational drugs? ☐ No ☐ Yes

Please List _____

Patient (print name) _____ Patient Signature _____ Date _____

Doctor (print name) _____ Doctor Signature _____ Date _____

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RECORDS RELEASE

I authorize the following provider to release my dental records (including, but not limited to: bitewing radiographs taken within the last 12 months, FMX and/or panoramic radiographs taken within the last five years, periodontal charting recorded in the last 12 months, and any other pertinent information necessary to provide care) to Scottsdale Smile Center.

Our mutual patient has an appointment scheduled with our office _____. Please transfer all records as soon as possible to ensure that they are available prior to the patient's arrival.

Previous Dentist Information:

Name _____

Address _____

Phone _____

Email _____

Patient (print name) _____

Patient Signature _____

Date _____