



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 _____



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 _____



SCOTTSDALE SMILE CENTER

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

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 _____