# SUNSHINE DENTISTRY AZ

## NEW PATIENT REGISTRATION FORM

Last name ______ First ______ Middle ______

Date of Birth ___/___/_____ SS# __________ Female_____ Male_____

If child, both parents names __________

Email for confirming appointments __________

Post Office Box ________ Steet Address __________

City __________ State ________ Zip ________

Home Phone ________ Work Phone ________ Cell: ________

When and where are the best times to reach you? __________

Employed by __________ Occupation __________

Work Address __________ How long there? ______

**WHOM MAY WE THANK FOR REFERRING YOU?** __________

SPOUSE INFORMATION

His/Her Name __________

Employer __________

Work# ________ Cell# ________

Birth date: ___/___/_____ SS# ________

PERSON RESPONSIBLE FOR ACCOUNT

His/Her Name __________

Relationship: ______ SS# ________

Hm# ________ Wk# ________

Cell# __________

Billing address __________

Employer __________

**PAYMENT PREFERENCE (Please Check one):**

Cash ______ (5% discount with advance payment on fees over $500) Credit Card ______

**DENTAL COVERAGE** Yes ____ No ____

Insurance Co. __________

Address __________

Phone# __________

Group # ________ Policy # ________

Insured's Name __________

Relationship __________

SS# ________ DOB ___/___/_____

Insured's Employer __________

Employer's Address __________

**SECONDARY INS. COVERAGE** Yes ____ No ____

Sec. Ins. Co. __________

Address __________

Phone # __________

Group # ________ Policy # ________

Insured's Name __________

Relationship __________

SS# ________ DOB ___/___/_____

Insured's Employer __________

Employer's Address __________

**Other family members seen by us** __________

13. ALLERGIES: Are you allergic to any of the following? (circle all that apply)

| | |
|---|---|
| Dental Anesthetics (Novocain) | Y ____ N ____ |
| Penicillin / antibiotics | Y ____ N ____ |
| Codeine or another narcotic | Y ____ N ____ |
| Aspirin | Y ____ N ____ |
| Latex | Y ____ N ____ |

14. FOR WOMEN: Are you using prescribed method of birth control? Y ____ N ____

| | |
|---|---|
| Are you pregnant? | Y ____ N ____ |
| Are you nursing? | Y ____ N ____ |

## Have you ever had any of the following diseases or medical problems (circle all that apply)

| | | |
|---|---|---|
| Abnormal bleeding | Frequent Headaches | Mitral Valve Prolapse |
| Alcohol / Drug abuse | Glaucoma | Osteoporosis / Paget's disease |
| Anemia | Hay fever | Pacemaker |
| Arthritis | Heart attack | Psychiatric Problems |
| Artificial Bones / joints / valves | Tuberculosis (TB) | Radiation treatment |
| Asthma | Hearth Surgery | Rheumatic / Scarlet fever |
| Blood transfusions | Hemophilia | Seizures |
| Cancer / Chemotherapy | Hepatitis (circle) A B C | Shingles |
| Colitis | Hearth murmur | Sickle cell disease / traits |
| Congenital Heart Defect | High blood pressure | Sinus problems |
| Diabetes | HIV / AIDS | Stroke |
| Difficulty Breathing | Kidney Problems | Thyroid problems |
| Emphysema | Liver Disease | TMJ |
| Epilepsy | Low blood pressure | Ulcers |
| Fainting spells | Lupus | Venereal disease |

**Please list any serious medical condition you have ever had:**

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

# MEDICAL HISTORY UPDATES

I have read my medical history and state that it confirms past and present medical conditions. I have provided the dental staff with any changes in my health status and changes in medications.

Signature ________________________________________ Date ____________ Reviewed by _____________

Signature ________________________________________ Date ____________ Reviewed by _____________

Signature ________________________________________ Date ____________ Reviewed by _____________

Signature ________________________________________ Date ____________ Reviewed by _____________

Signature ________________________________________ Date ____________ Reviewed by _____________

Email address for confirming appointments _______________________________________________________

I prefer to be called __________________________________________________________________________

If child both parent's names ____________________________________________________________________

# SUNSHINE DENTISTRY

## CONSENT FOR TREATMENT, PAYMENT AND PRACTICE OPERATIONS

Welcome to Sunshine Dentistry AZ, we are glad you have chosen our office as your provider and would like to provide you with the best possible dental care and service. To better help you become familiar with our office; we would like to address areas we feel are most important.

1) I give this practice my consent to use or disclose my protected health information to carry out my treatment and to obtain payment from insurance companies.
2) I have been informed that I may review the practice's NOTICE OF PRIVACY PRACTICES (for a more complete description of uses and disclosures) before signing consent.
3) I understand that this practice has a right to change their privacy practices and that I may retain any revised notices at the practice.
4) I understand that I have the right to request a restriction of how my protected health information is used. However; I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restrictions, they must follow the restriction (s).
5) I understand that I may revoke this consent at any time, by making a request in writing. Such a request will not apply to any information already used or disclosed prior to request.
6) Appointments. We take great pride in reserving your appointment in advance, and it is extremely important that you to keep your scheduled appointment. If an emergency arises, we ask that you give our office a **48-hour notice** to avoid a **$25.00** cancellation or no-show fee.
7) We are willing to provide patients with a copy of their x-rays and dental records but please be advised that there is a **$25.00** processing fee. We will always do our best to process your request within 3 business days.
8) Our hygiene department starts treating patients at the age of 4 years old, but Dr. Garfield does not begin to do restorative work until the age of 8 years old, however, if your child does need restorative work, we will be glad to provide you with the name of a pediatric dentist.
9) Billing. It is our office policy that payment is expected at the time service is rendered. As a courtesy to you, we will bill your primary insurance company and accept their payments along with your co-payments at each appointment. However, the ultimate investment for services lies strictly with the patient. Any discrepancy between our estimation of your insurance benefits and the actual payments is between you and your insurance company, if the insurances company has not paid their portion within 30 days, we ask that the payment be made in full by the patient. We do accept ALL major credit cards; we also accept Care Credit as a payment option.

Patient Name ______________________________

Signature ______________________________ Date: ______________

If signed by patient representative, state relationship to patient: ______________________

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