855 W/ Bell Rd, Ste 600
Nogales, AZ 85621
520-761-1600

Patient Information & Medical History

Date: ____/_____/20____

Patient's name ____ Preferred name _________________
Male/Female: ___________ Marital status: Married/Single ___________
Mailing address ____
City _________________________ State _____ Zip ______________
Home phone (_____)_____-__________ Mobile phone (_____)_____-___________
Birthdate ____/_____/_______ Social Security Number _____-_____-_________
Whom may we thank for referring you to our office? ______________________________________
Employer _____________________________________ Occupation ___________________________________
Number of years employed ____________

Parent/Guardian Information (if minor)
Name ____
Mailing address ____
City _________________________ State _____ Zip ______________
Home phone (_____)_____-__________ Mobile phone (_____)_____-_________
Birthdate ____/_____/_______ Social Security Number _____-_____-_________
Relationship to the patient ____________________________
Employer _____________________________________ Occupation ___________________________________
Number of years employed ____________

Spouses Information
Name ____
Mailing address ____
City _________________________ State _____ Zip ______________
Home phone (_____)_____-__________ Mobile phone (_____)_____-_________
Birthdate ____/_____/_______ Social Security Number _____-_____-_________
Relationship to the patient ____________________________
Employer _____________________________________ Occupation ___________________________________
Number of years employed ____________

Emergency Information
Name of nearest relative not living with you ____
Relationship ___________________
Mailing address ____
City _________________________ State _____ Zip ______________
Home phone (_____)_____-__________ Mobile phone (_____)_____-_________

Medical History
It is important that you answer the following to protect your health.

Name of family physician ____

Address ___________________________________ City __________ State _____ Zip __________

Are you currently under the care of a physician? _____ Date of last complete physical _______________

Have you been hospitalized within the last 2 years? _______

If so, please explain ____

List all medication you are currently taking ____

____

List any medication to which you have had an allergic reaction ___________________________________

Have you ever had any of the following?

Yes	No		Yes	No	
		Allergy to latex			Tuberculosis
		Rheumatic fever			Respiratory disease
		Heart trouble			Nervous condition
		Heart murmur (MVP)			Diabetes
		Artificial joints			Sinus problems
		Implanted plates/pins			Thyroid disorder
		High blood pressure			Kidney trouble
		Low blood pressure			Psychiatric care
		Pacemaker			Stroke
		Anemia or blood disorder			Hemophelia
		Asthma or hay fever			AIDS/HIV positive
		Radiation treatment			Excessive bleeding
		Convulsions or epilepsy			Other __________________________
		Bruxism (Night Grinding)			Other __________________________
		Hepatitis or liver disease			Other __________________________
		Arthritis			Other __________________________
		Cancer (type) __________________			Other __________________________

If female, are you pregnant? _________ If so, what month? _______________

Do you smoke? _______________ How many packs per day? ____________

Do you chew tobacco? _______________ How often? _____________________

Patient or Guardian Signature: ____ Date _____/_____/20___

Updates

Dates & initials __________ __________ __________ __________ __________ __________

__________ __________ __________ __________ __________ __________

Patient Dental History

Date _____/_____/20___ Name ____

What is the purpose of your visit today? ____

Are any or all of your teeth sensitive to _____ Heat _____ Cold _____ Sweets _____Biting or pressure

Yes	No	
		Do you have a fear of dentistry?
		Do you have any teeth that feel loose?
		Have you noticed any gum tenderness or swelling?
		Do you avoid either side when chewing or brushing?
		Do your gums bleed during or after brushing?
		Have you had periodontal treatments?
		Have you ever been told that you have periodontal disease?
		Are you aware that you may be clenching your teeth? ___ Day? ___ Night?
		Do your jaws feel tired, especially in the morning?
		Do you have pain in front of or above your ears?
		Do you have all or most of your natural teeth?
		Have missing teeth been replaced?
		If not replaced, are you concerned about the possible outcome?
		Have you had a complete series (16-20 films) within the last 3 years?
		Have you had your teeth cleaned and examined regularly?
		Have you ever been instructed regarding proper home care of your teeth?
		Do you use dental floss? How often? _______________
		How often do you brush your teeth? _______________

Please explain how you feel about your teeth. Are you happy with your smile?

____

____

____

Is there any other information you think we should know?

____

____

____

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CONSENT FOR TREATMENT, PAYMENT AND PRACTISE OPERATIONS

Welcome to Sunshine Dentistry Nogales! 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 Sunshine Dentistry Nogales my consent to use of 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 Sunshine Dentistry Nogales' NOTICE OF PROVACY PRACTICES for a more complete description of uses and disclosures before signing consent.

3. I understand that Sunshine Dentistry Nogales has the right to change their privacy practices and that I may retain any revised notice 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 Sunshine Dentistry Nogales 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 restriction at any time by making a request in writing. Such a request will not apply to any information already used or disclosed prior to the request.

6. Appointments. We take great pride in reserving your appointment in advance and it is extremely important that you keep your scheduled appointment. We ask that you give our office a **48 hour notice** in order to avoid a cancellation or no-show fee.

7. Our hygiene department starts treating patients at the age of two years old. Our dentists do not begin restorative work until six years of age, however, if your child does need restorative work, we will be happy to provide you with the name of a pediatric dentist.

8. 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 insurance company has not paid their share within 30 days we ask that the payment be made in full by the patient. We accept all major credit cards and Care Credit as payment options. Returned checks will be assessed a minimum $35 return fee.

Patient name ____

Signature ____ Date _____/_____/20___

If signed by a guardian, state relationship to patient ___________________________________