Desert Ridge Prosthodontics

Date: _____

Patient Name: _____ _____ DOB:_____

Last First MI

Address: _____ Home Phone _____

City _____ State _____ZIP _____

Work: _____ Cell: _____ E-Mail _____

What is the primary reason for your dental visit today? _____

How did you hear about our office? _____

MEDICAL HISTORY

	Yes	No		Yes	No
AIDS	☐	☐	Growths/Tumors	☐	☐
Artificial Joints	☐	☐	Heart Disease	☐	☐
Asthma/HayFever	☐	☐	High Blood Pressure	☐	☐
Allergies	☐	☐	Head Injuries	☐	☐
Arthritis	☐	☐	Kidney Disease	☐	☐
Blood Disorder	☐	☐	Liver Disease	☐	☐
Biosphophonates/Fosamax	☐	☐	Mental Disorders	☐	☐
Cancer	☐	☐	Nervous Disorders	☐	☐
Diabetes	☐	☐	Pregnancy	☐	☐
Dizziness	☐	☐	Due _____		
Epilepsy	☐	☐	Stroke	☐	☐
Glaucoma	☐	☐	Tuberculosis	☐	☐

Do you have any disease, condition, or problem not listed above that you think we should know about?

_____

Are you allergic or have had an adverse reaction to a specific medication? ☐ Yes ☐ No

Please list medications or allergies:_____

Are you currently under the care of a physician? ☐ Yes ☐ No If so, for what? _____

_____

DENTAL HISTORY

When was the last time you had a complete dental evaluation? _____

Have you ever had a serious/difficult problem associated with any previous dental work?

_____

Have you ever been informed or treated for the following dental conditions?

	Yes	No		Yes	No
Gum/Periodontal Disease	☐	☐	Oral Cancer/Biopsy	☐	☐
Cold Sores/Ulcers	☐	☐	TMJ/TMD Joint Pain	☐	☐
Bad taste/Odor			Jaw Surgery		
Hot/Cold Sensitivity	☐	☐	Other	☐	☐

PRIMARY INSURANCE INFORMATION

Name: _____ Date of Birth: _____ SSN: _____

Employer: _____

Insurance Plan Name _____ Group # _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

SECONDARY INSURANCE INFORMATION

Name: _____ Date of Birth: _____ SSN: _____

Employer: _____

Insurance Plan Name _____ Group # _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

EMERGENCY CONTACT INFORMATION

In case of an emergency whom may we contact:

Name _____ Relationship _____

Phone _____

INSURANCE

We will send your insurance claims electronically to your insurance company. We are happy to do this for you, but we want to stress that the contract you have is between you and your insurance company. In some cases, we may not be contracted providers for your insurance company. If this is the case, your out-of-pocket cost may be higher than if you went to a contracted office. You are ultimately responsible for following up on your insurance claims and for the unpaid balance. If this results in being sent to the collection agency you will be responsible for the collection fee and/or attorney's fee.

BROKEN APPOINTMENT

As a courtesy to you, we call the day before your appointment to confirm the time that has been reserved for you. We realize emergencies come up and appointments need to be cancelled. If you have an emergency, please call our office so we may try to fill the time we had reserved for you. ***If we do not hear from you 24 hours prior to your appointment, you will be charged $50.00 for a broken appointment.***

CONSENT FOR SERVICES

I give me consent for the doctors of Desert Ridge Prosthodontics to complete a thorough examination on me (my child), Including any needed diagnostic radiographs. To the best of my knowledge, the information that I have provided is correct and I understand that it will be held in the strictest of confidence and in accordance to all state and federal HIPPA regulations. I also understand that it is my responsibility to inform Desert Ridge Prosthodontics of any changes to my (child's) medical status.

_____ Date: _____
Signature (Parent or Legal Guardian)

Reset **Submit**