CACTUS DENTAL CARE
7440 W CACTUS RD #A-18
PEORIA, AZ 85381
623-979-4400

PERSONAL INFORMATION:

*Last Name*_____*First*_____*Middle*_____

*Address*_____*City*_____*Zip*_____

*SS#*_____*Date of Birth*_____*Home Phone#*_____

*Occupation*_____*Employer*_____*Cell Phone#*_____

*Physician & Office Phone*_____*Referred by*_____*Work Phone#*_____

*Email*_____ ***Male/Female*** ***Single/ Married / Divorced / Widowed***

RESPONSIBLE PARTY AND DENTAL INSURANCE INFORMATION:

*Name*_____*Home Phone#*_____*Date of Birth*_____

*Address*_____*Work Phone#*_____*SS# of Insured*_____

*Name of Dental Insurance*_____*Name of Insured*_____

*Employer*_____*Group Number*_____*SS# of Responsible Party*_____

MEDICAL AND HEALTH HISTORY: HAVE YOU EVER HAD ANY OF THE FOLLOWING (PLEASE CIRCLE Y OR N):

High Blood Pressure	Y / N	Diabetes (I, II, or Pregnancy)	Y / N	Gastric Problems	Y / N
Heart Murmur	Y / N	Asthma	Y / N	Intestinal Problems	Y / N
Rheumatic Fever	Y / N	Tuberculosis	Y / N	Urinary Tract Problems	Y / N
Stroke/Heart Attack	Y / N	Valley Fever	Y / N	Kidney Problems	Y / N
Abnormal Bleeding	Y / N	HIV or AIDS	Y / N	Dialysis	Y / N
Anemia	Y / N	Hepatitis (A, B, C, D, E, etc)	Y / N	Liver Problems	Y / N
Prosthetic Joints	Y / N	Sexually Transmitted Disease	Y / N	Psychiatric Treatment	Y / N

Are you allergic to LATEX? Yes / No Are you allergic to banana, avocado, or kiwi fruit? Yes / No
Are you allergic to antibiotics? Yes / No Which ones?_____
Are you allergic to any other medications? Yes / No Which ones?_____
Do you have any other allergies of any type?_____

What daily medication are you taking?_____
What "over-the-counter" medications?_____
What vitamin supplements are you taking?_____
What Herbal supplements are you taking?_____
Do you use any type of recreational drug? Y / N (All of this information is confidential...please discuss with the dentist.)

Are you taking oral birth control? Yes / No If so, what brand?_____
Are you pregnant? Yes / No If so, how many months?_____
What is the name and office telephone number of your OBGYN?_____

Do you smoke? Yes / No If so how many packs per day?_____Have you ever tried to quit?_____
Do you use smokeless tobacco? Yes / No How much, how often, and which side of the mouth?_____

AUTHORIZATION AND RELEASE:

I realize my dentist must occasionally confer with medical and dental specialists concerning my physical health as well as my dental health. Furthermore, I hereby subscribe that the above information is truthful and I consent to the release of medical and dental information related to my dental treatment.

Signed_____on this date_____.

DENTAL HISTORY:

Have you had an updated (within past three years) full set of x-rays, including 4 bite-wing and 14 periapical radiographs? Yes / No
If you have had this in another office, can you get a copy within the next two weeks? Yes / No

Do you have any unhealed injuries / sores / ulcers/ inflamed areas in or around your mouth? Yes / No
Do you have any growths or swelling in your mouth? Yes / No
Does your mouth hurt when you chew or clench? Yes / No
Does your jaw hurt when you wake in the morning? Yes / No
Do you have pain around your ear when you chew or when you wake? Yes / No

Have you ever had dental anesthetic (i.e. Novocain)? Yes / No
Have you had adverse reactions associated with dental anesthetic? Yes / No
If so explain_____

Have you had any difficulties with any dental treatment in the past? Yes / No
If so explain_____
Have you been told that you snore? Yes/No
Do you feel tired during the day or have trouble staying awake? Yes/No
Have you previously been diagnosed with sleep apnea? Yes/No
If yes:

A. Were you prescribed a CPAP machine? Yes/No
B. Do you use your CPAP machine? Yes/No

Do you wish to know more about dental cosmetic procedures: Yes / No
Do you wish to know more about Dental whitening procedures? Yes / No
Are there any changes to your smile you would like to discuss?_____

Cactus Dental Care and staff are intent upon providing quality dental care in a pleasant and comfortable atmosphere. Understanding the office policies will help you to help them create such an atmosphere as they are accommodate you and your dental needs. (A much more detailed list of office and financial policies is readily available upon request from the front office staff.)

OFFICE POLICY: PLEASE INITIAL EACH SECTION AS YOU READ THEM.

_____Full payment is due at time of service.

_____We submit and take insurance assignment of benefits **as a courtesy** to you. However, please be aware that some and perhaps all of the services provided may be non-covered services under your particular coverage. We give you an estimate only. You are responsible for any fees you insurance does not cover. The balance of your account is your responsibility within 30 days if your insurance company denies payment of a service. In the event that your account becomes overdue, charges are applied accordingly.

_____Minors must be accompanied by parent/guardian for **all** appointments. Minors that are accompanied by an older sibling or are not accompanied at all will be denied treatment. It is the Law.

_____The dentist sees only one patient at a time not only for you, but for all of his patients' convenience. Unless canceled at least one business day in advance, our policy is to charge $25 per half hour appointment for missed or canceled appointments with less than 24 hours' notice. Please be prompt for all scheduled appointments.

_____I understand that a detailed financial policy is available to me upon request and that I am responsible for the information in it whether I obtain a copy or not. That financial policy outlines specific fees for missed appointments, services charges, ect.

I have read, recognize, and understand the office policies.

Patient Signature _____Date_____

Financial policies received on this date:_____Office staff initials:_____