SHADOW RIDGE DENTAL CARE

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Soc. Sec. # _____
Last Name *First Name* *Middle Initial*

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by _____ Occupation _____

Business Address _____

Business Email _____ Business Phone _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____ Business Phone _____

Cell Phone _____ Email _____

Primary Insurance

Person Responsible for Account _____
Last Name *First Name* *Middle Initial*

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____

Business Email _____ Business Phone _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber's # _____

Name(s) of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber's # _____

Name(s) of other dependents under this plan _____

Please complete both sides

Dental History

What is the reason for your visit today? _____

Are you in dental discomfort today? _____

Former Dentist _____ Address _____ Phone _____

Dentist's Email _____

Date of last dental care _____ Date of last X-rays _____

Check Y for yes or N for no if you have or have not had the following:

☐Y ☐N Bad breath
☐Y ☐N Bleeding gums
☐Y ☐N Clicking or popping jaw
☐Y ☐N Food collection between teeth
☐Y ☐N Grinding or clenching teeth
☐Y ☐N Loose or broken fillings
☐Y ☐N Looseor broken teeth
☐Y ☐N Periodontal treatment
☐Y ☐N Sensitivity to hot/cold
☐Y ☐N Sensitivity to sweets
☐Y ☐N Sensitivity when biting
☐Y ☐N Sores or growths in mouth

How often do you brush? _____ How often do you floss? _____

How do you feel about the appearance of your teeth?_____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐Y ☐N

Other information about your dental health or previous treatment_____

Medical History

Physician's name _____ Phone _____

Physician's Email _____

Date of last visit _____ Have you had any serious illnesses or operations? ☐Y ☐N

If yes, describe _____

Are you currently under physician care? ☐Y ☐N If yes, describe _____

Have you ever had a blood transfusion? ☐Y ☐N If yes, give approximate date(s) _____

Women: Are you pregnant? ☐Y ☐N Nursing? ☐Y ☐N Taking birth control pills? ☐Y ☐N

Have you ever used a bisphosphonate medication? Brand names inlcude Fosomax, Actonel, Atelvia, Didronel and Boniva ☐Y ☐N

Check Y for yes or N for no if you have or have not had the following:

☐Y ☐N AIDS/HIV Positive
☐Y ☐N Anaphylaxis
☐Y ☐N Anemia
☐Y ☐N Arthritis, Rheumatism
☐Y ☐N Artificial heart valves
☐Y ☐N Artificial joints
☐Y ☐N Asthma
☐Y ☐N Back problems
☐Y ☐N Blood disease
☐Y ☐N Cancer
☐Y ☐N Chemical dependency
☐Y ☐N Chemotherapy
☐Y ☐N Circulatory problems
☐Y ☐N Cold sores
☐Y ☐N Cortisone treatments
☐Y ☐N Cough, persistent
☐Y ☐N Cough up blood
☐Y ☐N Diabetes
☐Y ☐N Epilepsy
☐Y ☐N Fainting
☐Y ☐N Food allergies
☐Y ☐N Glaucoma
☐Y ☐N Headaches
☐Y ☐N Heart murmur
☐Y ☐N Heart problems
Describe _____
☐Y ☐N Hemophilia/ Abnormal bleeding
☐Y ☐N Herpes
☐Y ☐N Hepatitis
☐Y ☐N High blood pressure
☐Y ☐N Jaw pain
☐Y ☐N Kidney disease or malfunction
☐Y ☐N Liver disease
☐Y ☐N Latex/Metal allergies
☐Y ☐N Marijuana use
☐Y ☐N Mitral valve prolapse
☐Y ☐N Nervous problems
☐Y ☐N Pacemaker/Heart surgery
☐Y ☐N Psychiatric care
☐Y ☐N Rapid weight gain or loss
☐Y ☐N Radiation treatment
☐Y ☐N Respiratory disease
☐Y ☐N Rheumatic fever
☐Y ☐N Scarlet fever
☐Y ☐N Shingles
☐Y ☐N Shortness of breath
☐Y ☐N Skin rash
☐Y ☐N Snoring/Sleep apnea
☐Y ☐N Spina Bifida
☐Y ☐N Stroke
☐Y ☐N Surgical implant
☐Y ☐N Swelling of feet or ankles
☐Y ☐N Thyroid disease or malfunction
☐Y ☐N Tobacco/Vape habit
☐Y ☐N Tonsillitis
☐Y ☐N Tuberculosis
☐Y ☐N Ulcer/Colitis
☐Y ☐N Venereal disease

Is patient currently taking any medications? if yes, list all.

_____

_____

Does patient have drug allergies? if yes, list all.

_____

_____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

I authorize Dr. Shaun Gardner to provide dental services necessary for proper care.

Signature_____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.

SHADOW RIDGE DENTAL CARE

Treatment Agreement:

The doctors and staff at Shadow Ridge Dental Care are committed to providing dental therapy that addresses the patient's special needs, concerns and problems. We will strive to make the overall experience as pleasant as possible. We expect that the patient will take an active role in his/her care. This means that the patient promises to ask questions whenever needed in order that they may better understand the recommended treatment, the recommended instructions prior to treatment and any instructions given following treatment. This will help to maximize treatment results and your overall dental experience.

Patient Responsibilities:

-Be courteous and professional to Doctor & staff
-Keep all scheduled appointments (**At least 24 hour notice is required to cancel/reschedule or $25 charge may apply**)
-Pay for treatment at the agreed time

Patient Awareness:

We do regularly send correspondence through mail, email, text message and phone calls. If at any time you would like to opt out of receiving your messages by one of these methods, please let us know. By signing this form, you are agreeing to receive all correspondence by all methods listed unless you request otherwise.

Financial Policy:

We are committed to providing you with the best possible care. In order to achieve this goal, we need your assistance and your understanding of our payment policy. Payment for services is due on or before the day services are performed unless other arrangements have been made and approved in advance by the Financial Coordinator. We accept cash, check, credit cards and Care Credit. Financial arrangements will only be made with a credit card on file and on case by case basis. Funds will be drafted on the agreed date. If any balance becomes delinquent over thirty (30) days, it is agreed that Shadow Ridge Dental Care will have the authority to debit my charge account listed above. We will impose a late payment charge of 1.5% per month (or maximum allowed by law).

If insurance is involved, we can file claims on your behalf in most cases. Please understand that this is a medical facility and the doctors care about your health. It is their responsibility to advise you of the status of your dental health and advice you of treatment needed based on your specific needs, not based on your insurance coverage.
WE WILL DO OUR BEST TO ESTIMATE FOR YOU WHAT INSURANCE WILL PAY AND WHAT THE PATIENT PORTION WILL BE FOR YOUR TREATMENT. THE ESTIMATED PATIENT PORTION WILL BE DUE AT THE TIME OF TREATMENT. ANY AMOUNT NOT PAID BY YOUR INSURANCE, REGARDLESS OF THE REASON, IS YOUR RESPONSIBILITY. We therefore require a credit card to be on file for any balance not paid by insurance company.

Circle preferred method of payment: VISA/MC/AMEX/DISCOVER/CARE CREDIT

CARD#_____ EXP DATE _____ CCV_____

CARDHOLDER SIGNATURE_____

Terms & Conditions:

I, the undersigned, agree to all financial policies as listed above.
All emergency dental services, or any dental services performed without prior financial arrangements, must be paid for by one of the above mentioned methods of payment the day services are performed.
I understand that all dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

SIGNATURE_____ DATE _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

SHADOW RIDGE DENTAL CARE

3970 E. Riggs Rd. Suite 3
Chandler, AZ. 85249
480.214.4898

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, you are bound to abide by such restrictions.

Patients Name: _____ Date: _____

Relationship to Patient: _____

Signature: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement,

Date:	Initials:	Reason:

Please Be Aware…

The doctors and staff at Shadow Ridge Dental Care are committed to providing dental therapy that addresses the patient's individual needs, concerns and problems. Please understand that this is a medical facility and the doctors care about your health. It is their responsibility to advise you of the status of your dental health and advise you of treatment needed based on your specific needs, not based on your insurance coverage.

As a patient, or a parent of a patient, you have the right to decline treatment before treatment is rendered. However, once treatment is rendered, you are responsible for the fee regardless of insurance coverage.

Your employer chose the specifics of your insurance coverage. We will file claims on your behalf in most cases. However, we do not take responsibility for your insurance plan, their fees, allowances, limitations and specifications. There are hundreds of insurance plans and it is impossible for us to know them all. **Therefore, it is the patient's responsibility to know and understand their individual plan**. We will be happy to try and assist you with your benefits and answer questions you may have. If you have specific questions about your plan however, you should contact your employer or your Insurance Company directly.

When Dual Insurance is involved…

We **cannot** give estimates when dual insurance is involved. Therefore, we will bill the primary insurance and then the secondary insurance. There is no guarantee that both insurances will pay on services. If you need to know for sure that both insurances will cover services you will need to contact your employer or your insurance companies directly and ask how they coordinate your benefits. The patient is responsible for any amount that is not covered by insurance regardless of the reason.

Remember….

WE WILL DO OUR BEST TO ESTIMATE WHAT INSURANCE WILL PAY AND WHAT THE PATIENT PORTION WILL BE FOR YOUR TREATMENT. THE ESTIMATED PATIENT PORTION WILL BE DUE AT THE TIME OF TREATMENT. ANY AMOUNT NOT PAID BY YOUR INSURANCE, REGARDLESS OF THE REASON, IS YOUR RESPONSIBILITY.

_____ _____

Signature Date