CONTEMPORARY DENTISTRY

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:

I prefer to be called:

Birthdate: SS#:

Home Address:

City: State: Zip:

Secondary Address:

Phone #: Mobile:

Email:

Employer: Occupation:

Please check all methods we may use to contact you:
☐ Home ☐ Mobile ☐ Email

Whom may we thank for referring you?

Other family members seen by us:

Responsible Party's Information

His/Her Name:

Birthdate: SS#:

Employer: Occupation:

Phone #:

Work #:

Email:

Emergency Contact

Name:

Relationship:

Phone #: Work #:

Email:

Dental Insurance

Primary Dental Insurance

Insurance Company:

Subscriber ID/Policy #:

Insured's Name:

Relation:

Insured's Birthday:

Insured's SS#:

Additional Dental Insurance

Insurance Company:

Insured's Name:

Relation:

Insured's Birthday:

Insured's SS#:

Preferred Pharmacy

Name of Pharmacy:

Address:

Phone #:

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Medical History

Patient Information

Name: Birthdate:

Physician's Name: Physician's Phone #:

Date of last visit: Have you had any serious illnesses or operations? ☐ Yes ☐ No

If yes, describe:

Are you currently under physician care? ☐ Yes ☐ No

If yes, describe:

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approx dates:

Have you ever taken Fen-Phen/Redux? ☐ Yes ☐ No

Have you ever used a **bisphosphonate medication**?
Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. ☐ Yes ☐ No

Do you smoke or use other tobacco/smokeless products? ☐ Yes ☐ No

Check all that apply: ☐ Cigarettes ☐ Marijuana ☐ Chew ☐ Vape Other:

Women: Are you pregnant? ☐ Yes ☐ No
Taking birth control pills? ☐ Yes ☐ No
Nursing? ☐ Yes ☐ No

Please check all current or former conditions:

- ☐ AIDS/HIV
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis / Rheumastism
- ☐ Artificial Heart Valves
- ☐ Artificial joints
- ☐ Asthma
- ☐ Allergy prone
  Describe:
- ☐ Back problems
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Congenital heart defect
- ☐ Cortisone treatments
- ☐ Persistent cough
- ☐ Cough up blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Food allergies
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart murmur
- ☐ Heart problems
  Describe:
- ☐ Hemophilia / abnormal bleeding
- ☐ Herpes
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Jaw pain
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Material allergies: **latex**, wool, metals, chemicals?
- ☐ Mitral valve prolapse
- ☐ Nervous problems
- ☐ Pacemaker / heart surgery
- ☐ Psyciatric care
- ☐ Rapid weight gain OR loss
- ☐ Radiation treatment
- ☐ Respiratory disease
- ☐ Rheumatic / Scarlet Fever
- ☐ Shingles
- ☐ Shortness of breathe
- ☐ Skin rash
- ☐ Spina Bifida
- ☐ Stroke
- ☐ Surgical implant
- ☐ Swelling of feet or ankles
- ☐ Thyroid disease
- ☐ Tobacco habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer / Colitis
- ☐ Venereal disease

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Other Medical Condition(s):

Does patient have drug allergies? If yes, list all:

Is patient currently taking any medications? If yes, list all:

Medication	Dosage	Reason for Taking Medication

Other:

Dental History

What would you like us to do today?

Are you in dental discomfort today? ☐ Yes ☐ No

Former Dentist:

Date of last dental visit: Date of last dental x-ray:

Please check any current or former problems:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding or clenching teeth
- ☐ Loose or broken tooth
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in mouth
- ☐ History of oral cancer

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

How do you feel about the appearance of your teeth?

Are you unhappy with any fillings, crowns or bridges? ☐ Yes ☐ No

If yes, describe:

Have you experienced an adverse reaction during a dental procedure? ☐ Yes ☐ No

If yes, describe:

Other information about your dental health or previous treatment:

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Smile Evaluation

We'd love to learn more about how you feel about your smile so we can help you achieve your goals.

1. How happy are you with the overall appearance of your smile?
□ Very happy □ Mostly happy □ Neutral □ Slightly unhappy □ Unhappy

2. Is there anything you'd like to change about your teeth or smile?
□ Color □ Shape □ Alignment (crowding, spacing) □ Size □ Gums (too high/low)
□ Other: _____

3. Do you have any chipped, worn, or discolored teeth that bother you?
□ Yes □ No If yes, please describe: _____

4. Have you ever considered or been interested in any of the following?
□ Whitening
□ Orthodontic alignment (Invisalign, clear aligners, braces)
□ Cosmetic bonding
□ Veneers
□ Replacing missing teeth (implants, bridges, partials)
□ Unsure / Would like to discuss options

5. How important is having a confident, attractive smile to you?
□ Very important □ Somewhat important □ Not a priority

6. Do you prefer a conservative approach (small improvements) or a more complete smile makeover?
□ Conservative / natural enhancements
□ Comprehensive cosmetic improvement
□ Not sure yet — would like guidance

7. Would you like our team to discuss cosmetic or alignment options at your visit?
□ Yes, please □ Maybe later □ Not at this time

I have reviewed the information on the questionnaires, 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 the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of the 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.

Signature: Date:

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

Doctor's Signature: Date:

GENERAL DENTAL TREATMENT CONSENT FORM

Purpose of Treatment

The goal of general dental care is to maintain and improve oral health by preventing, diagnosing, and treating dental disease. Common procedures include exams, cleanings, X-rays, fluoride treatments, sealants, fillings, and other preventive or restorative services as recommended.

Procedures

Treatment may involve the use of dental instruments, anesthetics, radiographs, and dental materials as appropriate. The dentist or hygienist will explain the procedures recommended for my specific needs and answer any questions before treatment begins.

Risks and Possible Complications

I understand that all dental procedures involve some risk, including temporary tooth or gum sensitivity, soreness of the gums, cheeks, or jaw, bite changes, allergic reactions to anesthetics or materials, and, in rare cases, infection or the need for additional treatment.

I understand that X-rays involve minimal radiation exposure, reduced by modern safety techniques.

I have been informed of alternatives to treatment, including doing no treatment, with the understanding that my condition may worsen without care.

Treatment Expectations and Financial Responsibility

I understand that results may vary from person to person, and no outcome can be guaranteed. If unforeseen conditions arise, additional treatment may be recommended.

I am responsible for all fees related to my care, regardless of insurance coverage or benefit determinations.

I understand that long-term success depends on good oral hygiene, regular visits, and following all post-treatment instructions.

Documentation and Records

I consent to the use of photographs, radiographs, and other records for diagnosis, treatment, and quality assurance, with full respect for my privacy. I also understand that select images may be used for educational or promotional purposes, including the practice’s website or social media, without identifying personal information.

Acknowledgment and Consent

I have been informed of the purpose, benefits, risks, and alternatives of general dental treatment and have had the opportunity to ask questions.

I understand that dentistry is not an exact science, and while no specific result can be guaranteed, my dentist and team will make every reasonable effort to achieve the best possible outcome and ensure my comfort.

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

CONTEMPORARY DENTISTRY

6900 E US Highway 60, Ste 110
Gold Canyon, AZ 85118
(480) 983-3444

HIPAA CONSENT FORM

Patient Name (please print): Date:

Patient DOB:

HIPAA- Notice of Privacy Practices HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of the notice Privacy Practice is to explain how Contemporary Dentistry may use or disclose your healthcare information. The notice also explains the rights that you are guaranteed under HIPAA regulations. Contemporary Dentistry is required by the HIPAA Privacy Rule to distribute this notice to you and obtain acknowledgement that you have received the notice. Signing below indicates that you have received the Notice of Privacy Practices. I hereby acknowledge that I have received or requested to receive a copy of Contemporary Dentistry Notice of Privacy Practices.

Patient Signature (or Guardian)

Permission to Share Medical/Dental Information:

My medical/dental information may be obtained and/or exchanged written or verbally to:

(Printed Name and Relationship)

Patient Signature (or Guardian) **Date**

CONTEMPORARY DENTISTRY

ELECTRONIC BILLING - I consent for Contemporary Dentistry to send billing information to:

☐ Text ☐ Email ☐ Both

FINANCIAL AGREEMENT - Payment in full / estimated co-insurance for all charges is required at time of treatment, unless prior arrangements have been made.

INSURANCE FILING - You, the patient, are ultimately responsible for payment in full on your account, not the insurance company. We do, however file dental insurance claims ***as a courtesy*** for our patients. We can only make estimates regarding your insurance benefits based on the information provided by you and the insurance company. In the event your insurance company does not pay as much as expected, the remaining balance is due and payable immediately by you, the patient.

ASSIGNMENT OF INSURANCE BENEFITS - I/we hereby assign directly to Contemporary Dentistry insurance benefits other wise payable to me/us. I/we herby authorize the release of any information relating to any claims. I/we are financially responsible for charges not paid by the assignment.

DELINQUENT ACCOUNTS - All delinquent accounts (30 days or older) are subject to reasonable service charges and/or legal interest rates.

COLLECTION POLICY - In the event your account is turned over to a collection agency for non-payment or other delinquency, you will be responsible for payment of any collection cost and/or attorney fees, in addition to the balance owed. Any account turned over to a Collection Agency forfeits any past special fees and/or discounts. Such special fees and/or discounts will be reversed and you will be responsible for payment of regular fee for the procedures at the time of service.

CANCELLATION POLICY - An appointment is an agreement between you and our office. Our part involves reserving the dentist, staff, and office time for you. Due to the ever-increasing demand for our services, we kindly request that if you must reschedule and appointment, please extend us the courtesy of ***48-hour*** notice. This courtesy will make it possible to give your reserved time to another patient. Any failed appointment or cancellation with less than ***48-hour*** notice may be subject to a $50 fee. While we realize that emergencies do happen and are not anticipated, all efforts to notify us are greatly appreciated.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I have received/offered a copy of the office's Notice of Privacy Practices. I understand that I have a right to refuse to sign this acknowledgment.

_____

Responsible Party Signature