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* *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 Phone _____

City _____ State _____ Zip _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Phone _____

Primary Insurance

Person Responsible for Account _____
Last Name *First Name* *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 Phone _____

City _____ State _____ Zip _____

Insurance Company _____ Phone _____

Insurance Address _____

Group # _____ Member ID # _____

Name of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber 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 Address _____

Insurance Company _____ Phone _____

Insurance Address _____

Group # _____ Member ID # _____

Name of other dependents under this plan _____

Medical History

Physician's name _____ Phone _____

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 dates _____

Have you ever taken Fen-Phen/Redux? ❑ Y ❑ N

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

Check (✓) yes or no whether you have had any of 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 Cortisone treatments
❑ Y ❑ N Cough, persistent
❑ Y ❑ N Dental Anesthetics
❑ 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 Material allergies (**latex**, wool, metal, chemicals, mint)
❑ Y ❑ N Mitral valve prolapse
❑ Y ❑ N Nervous problems
❑ Y ❑ N Pacemaker/ Heart surgery
❑ Y ❑ N Psychiatric care
❑ Y ❑ N Radiation treatment
❑ Y ❑ N Respiratory disease
❑ Y ❑ N Rheumatic/Scarlet fever
❑ Y ❑ N Shingles
❑ Y ❑ N Shortness of breath
❑ Y ❑ N Skin rash
❑ Y ❑ N Stroke
❑ Y ❑ N Surgical implant
❑ Y ❑ N Swelling of feet or ankles
❑ Y ❑ N Thyroid disease or malfunction
❑ Y ❑ N Tobacco 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 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 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.

Signature _____ Date _____

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

Patrick L. Dobash D.D.S., P.C.
13943 N. 91st Ave, Suite H-102
Peoria, Arizona 85381-3689
623-974-0500
Fax: 623-974-2212

Dental History

PATIENT'S NAME: _____

- How long has it been since your last dental cleaning? _____
- Have you ever been told you have gum disease? _____
- If yes, have you ever had gum surgery? _____
- Are you currently seeing a periodontist? _____
- Do you have any dental implants? _____
- Do you wear dentures or partials? _____
- If yes, how old are your dentures or partials and are you having any problems with the fit?_____
- Have you had your wisdom teeth removed? _____
- How often do you floss your teeth? _____
- Do you smoke, if yes how many packs a day do you smoke? _____
- Are you currently having any dental problems (broken teeth, pain and swelling, etc.)? Please explain: _____
  _____
  _____

PATRICK L. DOBASH, D.D.S., P.C.

OUR FINANCIAL POLICY

Thank you for choosing us as your dental provider. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatment needed to restore and maintain your dental health. Therefore, if you have any questions or concerns about our fees and payment policies, please do not hesitate to ask the front office.

We require all procedures be paid for at the time services are rendered. Our services may be paid for as follows: cash or check, Visa, Mastercard, Discover, and American Express. For patients paying the **total** fees charged for services rendered at that visit, we offer a 10% discount when paying by cash or check. We also offer "Care Credit" financing program. This allows you to finance your dental work with a credit company upon approved credit. Please ask our front office if you would like more information about Care Credit.

If you have dental insurance, please note the following:
If you provide us with current and accurate insurance information, as a courtesy, we will submit a claim to your insurance company. At the time of treatment, we will collect your estimated portion (this generally consists of deductibles and co-payments). Please understand that this is an **estimate**.

It is extremely difficult for us to keep track of all the individual insurance plans. Each one has different stipulations regarding coverage, exclusions and limitations, as well as who may provide services. **You are responsible for knowing the details of your dental insurance plan.** Since all estimates are subject to final approval by your dental insurance plan, the amount due is subject to change after final explanation of benefits have been paid. If the insurance company does not cover all charges, you will be responsible for any amount remaining on your account.

If your insurance carrier has not paid within sixty (60) days of submission, you are responsible for payment in full of any outstanding balance. Balances older than ninety (90) days may be turned over to a collection agency and collection charges may be added to the balance.

All appointments are scheduled on a reserved time basis. Please notify us at least 24 hours in advance (not including weekends or holidays) if you cannot keep your appointment. For appointments cancelled or missed with less than 24 hours notice, there is a failed appointment fee of $35.00.

I HAVE RECEIVED THE ABOVE FINANCIAL POLICY AND AGREE TO COMPLY WITH ALL OF THE TERMS AND CONDITIONS AND UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF PROCEDURES AT PATRICK L. DOBASH, D.D.S., P.C.

Signature: _____ Date: _____