OASIS FAMILY DENTISTRY

SAHIL ARORA, DDS

QUALITY • CARING • COMMITTED

WWW.OASISDENTALAZ.COM
Tel: 480-926-4498
1467 W ELLIOT RD, STE #101
GILBERT, AZ 85233

PATIENT INFORMATION

Date: _____

Patient: _____

FIRST MI LAST PREFERRED TITLE

☐MALE ☐FEMALE ☐CHILD* ☐STUDENT** ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:

_____
PARENT/GUARDIAN NAME(S)

**IF STUDENT, PLEASE COMPLETE: ☐FULL-TIME ☐PART-TIME

_____
SCHOOL/LOCATION

Patient Date of Birth: _____ Patient SSN: _____

Address: _____
ADDRESS LINE 1

_____ CELL: _____
ADDRESS LINE 2 WORK: _____

_____ OTHER: _____
CITY ST ZIP CODE _____

E-Mail: _____ _____

Referral? ☐Yes ☐ No Referred by: _____

INTERNET SEARCH☐ WEBSITE☐ MAILER☐ INSURANCE☐

SOCIAL MEDIA ☐ OTHER☐

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person:

_____ _____
NAME RELATIONSHIP MOBILE

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

Phone #: _____ Email: _____

INSURANCE INFORMATION

Subscriber: _____
FIRST MI LAST PREFERRED TITLE

Subscriber Date of Birth: _____ Subscriber SSN/ID#: _____

Subscriber Employer: _____

Patient Relationship to Subscriber: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER

PRIMARY INSURANCE CARRIER: _____

Group/Policy No.: _____ ID No.: _____

Address: _____ TEL: _____

_____ TOLL-FREE: _____

_____ FAX: _____
CITY ST ZIP CODE

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PREVIOUS DENTIST INFORMATION

Dentist: _____ Telephone: _____

Clinic/Facility: _____

_____

CITY ST ZIP

Reason for changing: _____

DENTAL HISTORY

ORAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

Date of Last Dental Visit: _____ Treatment Type: _____

Would you like to have anOral ID cancer screening? ☐Y☐N

**Note: Some insurance plans do not cover this service; please check your plan documents for details.*

☐Y☐N Are you currently having dental discomfort? If yes, explain: _____
☐Y☐N Any unhappy/unpleasant dental experiences? If yes, explain: _____
☐Y☐N Any injuries to mouth/teeth/head? If yes, explain: _____
☐Y☐N Any missing teeth other than wisdom teeth or orthodontic extractions?
☐Y☐N Have missing teeth been replaced?
☐Y☐N Orthodontic appliances now or in the past? If yes, When? _____
☐Y☐N Are you interested in Orthodontic Treatment?
☐Y☐N Gums bleed when brushing or flossing?
☐Y☐N Concerned about gum disease? History of gum disease? ☐Y☐N
☐Y☐N Any concerns about the appearance of your teeth?
☐Y☐N Does it hurt to bite or chew?
☐Y☐N Do you clench or grind your teeth? If so, do you wear a night guard or splint? ☐Y☐N
☐Y☐N Do you want to become a regular continuing care patient in our practice?
☐Y☐N Do you want your mouth properly restored and pain free?
☐Y☐N Does any type of dental treatment make you nervous? If yes, please explain below:

_____

The most important concerns regarding my dental treatment are:

_____

What factors are most important for your satisfaction with our office?

_____

Any additional concerns/comments?

_____

CHILD/MINOR PATIENTS: PLEASE ANSWER THE FOLLOWING QUESTIONS:

☐Y☐N Any mouth habits? (thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc.)

_____

☐Y☐N Any unusual speech habits? If yes, explain: _____
☐Y☐N Any lost teeth? If yes, list: _____
☐Y☐N Does the patient receive assistance with brushing and flossing? If yes, how often?

_____

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PRIMARY PHYSICIAN INFORMATION

Patient Name: Last Date of Visit:

Physician: Clinic/Facility: Telephone:

MEDICAL HISTORY

GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

☐Y☐N Under a physician's care now?
☐Y☐N Any hospitalization in the past 5 years? _____
☐Y☐N Any serious illnesses/surgeries? _____
☐Y☐N Use tobacco in any form? If yes, type: _____
☐Y☐N Is pre-medication required before dental visits due to heart condition or artificial joint?
☐Y☐N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

FEMALE PATIENTS: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant? Due Date: _____

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ACID REFLUX
☐AIDS/HIV
☐ANEMIA
☐ANXIETY
☐ARTIFICIAL HEART VALVE
DATE:_____
☐ARTIFICIAL JOINTS
DATE:_____
☐ARTHRITIS
☐ASTHMA
☐AUTISM/ASPERGER'S
☐BLEEDING DISORDER
☐BULIMIA
☐CANCER/MALIGNANCY
☐CEREBRAL PALSY
☐CHEMICAL DEPENDENCY
☐DIABETES
☐DIZZINESS/FAINTING
☐EPILEPSY/SEIZURES
☐FREQUENT HEADACHES
☐HEARING PROBLEMS
☐HEART ATTACK
DATE:_____
☐HEART DISEASE
☐HEART MURMUR
☐HEPATITIS
☐HIGH BLOOD PRESSURE
☐KIDNEY DISEASE
☐LIVER PROBLEMS
☐MITRAL VALVE PROLAPSE
☐PACEMAKER
DATE:_____
☐PSYCHIATRIC TREATMENT
_____
☐RADIATION/CHEMO
DATE:_____
☐RESPIRATORY DISEASE
☐RHEUMATIC FEVER
☐SINUS PROBLEMS
☐STROKE
DATE:_____
☐THYROID CONDITION
☐TUBERCULOSIS
☐ULCERS
☐VENEREAL DISEASE
☐OTHER – PLEASE LIST:
_____

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ASPIRIN ☐CODEINE ☐METAL SENSITIVITY ☐SULFA DRUGS ☐NONE
☐ANESTHETIC – LOCAL ☐FOOD ☐NITROUS OXIDE SEDATION ☐PENICILLIN/OTHER ANTIBIOTICS
☐BARBITURATES ☐LATEX ☐SLEEPING PILLS
☐OTHER – PLEASE LIST: _____

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ANTIBIOTICS/SULFA DRUGS ☐ANTIHISTAMINES/ALLERGY ☐DAILY ASPIRIN ☐BLOOD PRESSURE MEDICATIONS
☐BLOOD THINNERS ☐CANCER/CHEMO MEDICATIONS ☐CORTISONE/STEROIDS ☐HEART MEDICATION/DIGITALIS
☐INSULIN ☐NITROGLYCERIN ☐ORAL CONTRACEPTIVES ☐OSTEOPOROSIS MEDICATIONS
☐OTHER DIABETIC MEDICATIONS ☐RECREATIONAL DRUGS ☐THYROID MEDICATIONS ☐TRANQUILIZERS
☐OTHER (PLEASE LIST BELOW **OR** ON FOLLOWING PAGE IF SPACE IS NEEDED)

Is there anything important about your medical condition we have not asked? ☐Y☐N If yes, please describe:

_____

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PATIENT NAME:		DATE:
DRUG NAME	**DOSAGE**	**REASON PRESCRIBED**

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Financial Guidelines

We are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.

Insurance

We accept all major dental insurance payments, however we may not be an in network provider for your plan. If we are not an in network provider, review your plan details, as in many cases insurance reimbursement is very similar.

- **We are in network for Delta Dental Premier.**
- **No estimate is a guarantee of payment.** Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, you would be responsible for the difference.
- **Minors must be accompanied by a parent or legal guardian**. If the parents are separated or divorced, the person accompanying the minor will be responsible for co-payment at the time of service.

Payments

- **Patient portion or patient co-pay is due at the time services are rendered** - unless **prior** financial arrangements have been made.
- **Payment Information:**
  - All major credit cards are accepted (Visa, MasterCard, Discover)
  - Various financing options with CareCredit®
- **Balances left over 90 days will incur an 18% or $10 minimum monthly finance charge.**

Short Notice Cancellation/ Missed Appointments

- **Please give 48 hours notice** if you are unable to keep your reserved time. Unless an emergency occurs, we expect to run on time for your appointment. We appreciate the same courtesy from you.
- **Short Notice Cancellation or missed appointments** will be charged $50.

By signing below I acknowledge I have read and understand the guidelines above.

Signature:_____ Date:_____

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Updated 2019

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office 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 and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: _____ **Date:**_____

RELATIONSHIP TO PATIENT: ☐SELF ☐PARENT ☐GUARDIAN ☐OTHER☐

Please list any dependent children under the age of 18 also covered by this acknowledgement:

PATIENT CONSENT - PAYMENT AUTHORIZATION - SIGNATURE ON FILE

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

I hereby authorize payment directly to *Oasis Family Dentistry* of the dental benefits otherwise payable to me.

I hereby authorize *Oasis Family Dentistry* to release any information concerning my health or dental care, advice, treatment or supplies provided. This information is to be used in administering dental claims and/or discussing treatment options with other dental professionals.

I understand and agree that (regardless of my insurance status) **I am ultimately responsible for the balance on my account for any professional services rendered.**

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Signature: _____ Date: _____