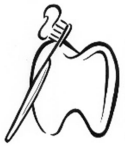

# DESERT SPRINGS FAMILY DENTISTRY

## New Patient Information

Last Name: _____ First Name: _____

Title: _____ Nickname: _____ Marital Status: _____

Sex: _____ DOB: _____/_____/_____ Social: _____-_____-_____

Guardian First and Last Name: _____

Address: _____

Apt #: _____City: _____ State: _____ Zip Code: _____

E-mail Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Preferred: _____

Previous Dentist Office: _____

Previous X-rays: _____Previous Dentist Office Phone: _____

Preferred Pharmacy

Location: _____

Number: _____

Primary Physician: _____

Physician's Phone:

_____

Emergency Contact Information:

Name and Phone: _____

Name and Phone: _____

## Insurance Information

### Primary

Policyholder Name: _____

Policyholder Address (If different from above)

_____

Relationship to patient: _____

Policyholder Social: _____-_____-_____ Policyholder DOB: _____/_____/_____

Employer Name: _____

Employer Phone: _____

Insurance Name: _____

Insurance Address: _____

Insurance Phone: _____

Group Number: _____

ID Number: _____

### Secondary

Policyholder Name: _____

Policyholder Address (If different from above)

_____

Relationship to patient: _____

Policyholder Social: _____-_____-_____ Policyholder DOB: _____/_____/_____

Employer Name: _____

Employer Phone: _____

Insurance Name: _____

Insurance Address: _____

Insurance Phone: _____

Group Number: _____

ID Number: _____

# Medical History

**Medications:**

| |
|---|
| |

**Please Answer The Following Questions:**

Do you smoke or use tobacco? _____

If so how often and how much: _____

**For women:**

Are you taking Birth Control? _____

Are you Pregnant? _____

How many weeks? _____

Are you nursing? _____

**Allergies:**

**Please check all that apply:**

| | |
|---|---|
| | Aspirin/Tylenol/Ibuprofen |
| | Anesthetics |
| | Amoxicillin |
| | Codeine |
| | Erythromycin |
| | Jewelry |
| | Latex |
| | Metals |
| | Penicillin |
| | Sulfa |
| | Tetracycline |
| | Other: _____ |

**Conditions:**

**Please check ALL that apply:**

| | |
|---|---|
| | Abnormal Bleeding |
| | |
| | Alcohol Abuse |
| | Allergies |
| | Anemia |
| | Angina Pectoris |
| | Arthritis |
| | Artificial Bones |
| | Artificial Heart Valve |
| | Asthma |
| | Back and Neck Pain |
| | Blood Transfusion |
| | Cancer-Chemotherapy |
| | Chest Pain |
| | Colitis |
| | Congenital Heart Defect |
| | Currently Taking Bisphosphonates |
| | Diabetes |
| | Difficulty Breathing |
| | Drug Abuse |
| | Emphysema |
| | Epilepsy |
| | Fainting Spells |
| | Fever Blisters |
| | Frequent Headaches |
| | Glaucoma |
| | HIV/AIDS |
| | Hay Fever |
| | Heart Attack |
| | Heart Surgery |

| | |
|---|---|
| | Hemophilia |
| | Hepatitis A |
| | Hepatitis B |
| | Hepatitis C |
| | High Blood Pressure |
| | Joint Replacement |
| | Kidney Problems |
| | Liver Disease |
| | Low Blood Pressure |
| | Joint Replacement<br>When:<br>Premedication Required: Yes or No |
| | Mitral Valve Prolapse |
| | Pace Maker |
| | Pain in Jaw Joints |
| | Psychiatric Problems |
| | Radiation Therapy |
| | Rheumatic Fever |
| | Seizures |
| | Sickle Cell Disease |
| | Sinus Problems |
| | Stroke |
| | Swollen Glands/Coughing |
| | Thyroid Problems |
| | Tuberculosis |
| | Ulcers |
| | Venereal Disease |
| | Vertigo |
| | Yellow Jaundice |
| | Other |

Signature: _____ Date: _____

(If under 18, Parent or Guardian Signature Required)

**Desert Springs Family Dentistry**

**FINANCIAL RESPONSIBILITY FORM**

If you have dental insurance, we will file the claims for you, as a complimentary service. It is very important that the correct insurance information is provided at the time of the patient's appointment. If this information changes, it is the patient's responsibility to update Desert Springs Family Dentistry at their earliest convenience. While we do our best to verify dental benefits prior to your first appointment, this does not guarantee coverage or payments to Desert Springs Family Dentistry. Although we may be a preferred provider with your dental insurance carrier, it is a contract between you, your employer and the insurance company.

We will provide you with a verbal ESTIMATE of your out of pocket expense for any treatment planned by the doctor. However, please understand that these are strictly estimates and are not a guarantee that your insurance company will reimburse us/you according to these estimates. While the filing of insurance claims is a courtesy that we extend to all of our patients, all charges are your responsibility from the date the services are rendered. If difficulty arises with payment from the insurance company that we are unable to resolve, we will ask that you contact your carrier to rectify the problem. All expected insurance balances remaining unpaid after 90 days from the date of service becomes the immediate responsibility of the patient and/or account holder.

Payment for co-pays and/or deductibles is due at the time services are provided. We accept all major credit cards as well as cash and personal checks. Desert Springs Family Dentistry also accepts the Care Credit health care card which offers several zero interest financing options with up to 12 months to pay. Information about Care Credit is available at our front desk. If a payment has not been received on your account for more than 90 days, the account risks being sent to a collection agency or an attorney. Any additional collection or attorney fees will be applied to the unpaid balance and will be the responsibility of the account holder.

Any personal check returned unpaid or with non-sufficient funds (NSF) will incur a $35 NSF check fee and may also subject you to court costs and attorney fees.

Missed appointments prevent others from receiving the dental care they deserve. Therefore, to reschedule or cancel an appointment you must notify us at least 24 hours in advance. A cancellation fee of $30 may be charged if a 24 hour notice is not given.

I acknowledge having read this Financial Responsibility Form in its entirety and agreed to be bound by all terms and conditions herein.

_____ _____/_____/_____

Patient name (print) Date

_____ _____

Responsible party signature Relationship to patient