WELCOME to Terravita Smiles

We are pleased to welcome you to Terravita smiles. Please take a few minutes to fill out these forms as completely as your can. We look forward to working with you in maintaining your dental health.

PATIENT DEMOGRAPHICS

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Social Security: _____

Sex: _____ Single Married Widowed Separated Divorced

CONTACT

Home: _____ Work: _____ Cell: _____

May we leave a detailed message? YES NO If yes, please circle preferred number above

Email: _____

ADDRESS

Address: _____

City: _____ State: _____ Zip Code: _____

Employer: _____ Occupation: _____

EMERGENCY CONTACT

Last Name: _____ First Name: _____

Phone Number: _____ Relationship to Patient: _____

INSURANCE/POLICY HOLDER

Plan Name: _____ ID Number: _____ Group Number: _____

Subscriber Last Name: _____ First Name: _____

Date of Birth: _____ Relationship to Patient _____

Is there a second dental insurance policy? YES NO

PRIMARY PHYSICIAN: _____ Phone: _____

PHARMACY: _____ Phone: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

TERRAVITA SMILES DENTAL AND MEDICAL HISTORY FORM

Name: _____ Date of Birth: _____
Reason for today's visit: _____ Any dental discomfort? _____
Former Dentist: _____ Phone number: _____
Date of last dental visit: _____ Date of last x rays: _____

Please CIRCLE if you have had problems with any of the following:

Bad Breath	Food collection between teeth	Periodontal treatment	Sensitivity to sweets
Bleeding gums	Grinding or clenching teeth	Sensitivity to cold	Sensitivity when biting
Clicking jaw	Jaw pain	Sensitivity to hot	Sores in mouth

How do you feel about the appearance of your teeth? _____
Have you had an adverse reaction during or in conjunction with a medical/dental procedure? _____
Other information about your dental health or previous treatment? _____

MEDICAL HISTORY

ARE YOU ON ANY BLOOD THINNERS- ASPIRIN INCLUDED: YES NO

Please list your CURRENT MEDICATIONS: _____
_____
_____

Women: Are you pregnant- Yes No Nursing: Yes No Taking birth control: Yes No
Please CIRCLE any MEDICATION ALLERGIES: Penicillin Sulfa Codeine Latex Iodine Adhesive
Other allergies medications/food/materials: _____

PAST MEDICAL HISTORY

YES	NO	Anaphylaxis	YES	NO	High Cholesterol/lipids
YES	NO	Anemia	YES	NO	HIV positive
YES	NO	Arthritis	YES	NO	Hypertension/High BP
YES	NO	Artificial Joints	YES	NO	Kidney disease
YES	NO	Asthma	YES	NO	Liver disease
YES	NO	Autoimmune/lupus	YES	NO	Lung disease
YES	NO	Cancer	YES	NO	Pacemaker/ht surgery
YES	NO	Chemical dependency	YES	NO	Parkinson's disease
YES	NO	Chemotherapy	YES	NO	Phen/Fen/Redux
YES	NO	Congestive heart failure	YES	NO	Radiation treatment
YES	NO	Cortisone treatment	YES	NO	Rheumatic fever
YES	NO	Diabetes	YES	NO	Scarlet fever
YES	NO	Emphysema/COPD	YES	NO	Seizures/epilepsy
YES	NO	Heart Murmur	YES	NO	Shingles
YES	NO	Herniated back disc	YES	NO	Sleep apnea
YES	NO	Herpes	YES	NO	Stroke
YES	NO	Headaches/migraines	YES	NO	Thyroid disease

Information on this questionnaire 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 are changes, I will inform the dentist.

Signature: _____ Date: _____

TERRAVITA SMILES
34522 N SCOTTSDALE ROAD, SUITE 140
SCOTTSDALE, AZ 85266

Financial Policies and Missed Appointment Policies

HIPAA Consent

In order to enhance communication and promote understanding regarding this office's financial and missed appointment policy, please read through the following information. After reading, please provide your signature at the bottom indicating that you fully understand these policies. This form must be signed in order to proceed with your scheduled appointment. If you have any questions or concerns, please speak to the front office staff.

INSURANCE: We are happy to bill both your primary and secondary insurance carriers as a courtesy to our patients. Please understand that each patient is ultimately responsible for the cost of services rendered. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to the contract. Our financial relationship is with you, not your insurance company.

1. All charges are your responsibility whether your insurance company pays or not. Not all services are covered benefits in all contracts.
2. If the insurance company does not pay in full within 60 days, we will ask that you pay the balance due.
3. We will do our best to estimate insurance coverage and patient co-pays due. (We will send a pre-estimate to the insurance company for treatment over $500 at the patients request). If the insurance does not pay the amount anticipated, the patient is responsible for the difference. Payment is expected within 10 days after the statement date.

PATIENT PAYMENT: Payment is due at the time services are rendered. For larger cases, 10% is due at scheduling to hold the reserved time with Dr. Asadi. If a down payment is made to hold an appointment and the appointment is cancelled, there will be a credit card processing fee for refunds made to credit cards. This would include reserved times that consist of 3 or more hours.

NO SHOW/MISSED APPOINTMENTS: We request 48 hour's notice for cancellation of appointments. If appropriate notice is not given, a charge of $50 may be assessed to the patient's account. For appointments longer than 3 hours, the charge will be $150. We understand that sometimes last- minute cancellations are unavoidable. Individual circumstances may be discussed with the front office staff or Dr. Asadi.

REFUNDS: Please understand that if a patient decides to discontinue treatment after it has been started, a full refund will not be given. Individual circumstances may be discussed with the office manager and/ or Dr. Asadi. Please be advised that if refunds are made to credit cards there will be a charge for the credit card processing fee.

CREDITS ON ACCOUNTS: If an insurance company pays more than anticipated creating a credit for the patient, we are happy to either refund the patient or leave the credit on the account to be applied to future treatment.

Patient Name: _____ Patient Signature: _____

Guarantor Name: _____ Guar. Signature: _____

Date: _____

Patient Acknowledgment of HIPAA Notice of Privacy

Patient Name: _____

Thank you for taking the time to review how we are protecting your health information. If you have any questions, please ask the office staff. If not, we would appreciate your acknowledging your receipt of the HIPAA policy by signing.

Patient Signature: _____