Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Last Name _____

Patient First Name _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex _____ Age _____

Birthdate _____

____ Married ____ Widowed ____Single ____ Minor

____ Separated ____ Divorced ____ Partnered for ____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ___Yes ___No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Mosley all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Mosley may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient _____

Print your name _____

Date _____ Relationship to Patient _____

Phone Numbers

Home (_____) _____ Work (_____) _____

Cell Phone (____) _____ Best time to reach you _____

Spouse's Work (____) _____

IN CASE OF EMERGENCY, CONTACT (specify someone who does not live in your household)

Name _____

Relationship _____

Home Phone (____) _____ Work (____)_____

Dental History

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit_____

Date of last dental X-rays _____

How often do you floss?_____

How often do you brush? _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

__Yes __No	Bad breath	__Yes __No	Bleeding Gums
__Yes __No	Blisters on lips or mouth	__Yes __No	Burning sensation on tongue
__Yes __No	Chew on one side of mouth	__Yes __No	Cigarette, pipe, or cigar smoking
__Yes __No	Clicking or popping jaw	__Yes __No	Dry mouth
__Yes __No	Fingernail biting	__Yes __No	Food collection between the teeth
__Yes __No	Foreign objects	__Yes __No	Grinding teeth
__Yes __No	Gums swollen or tender	__Yes __No	Jaw pain or tiredness
__Yes __No	Lip or cheek biting	__Yes __No	Loose teeth or broken filings
__Yes __No	Mouth breathing	__Yes __No	Mouth pain, brushing
__Yes __No	Orthodontic treatment	__Yes __No	Pain around the ear
__Yes __No	Periodontal treatment	__Yes __No	Sensitivity to cold
__Yes __No	Sensitivity to heat	__Yes __No	Sensitivity to sweet
__Yes __No	Sensitivity when biting	__Yes __No	Sores or growths in your mouth

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimim, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine) ____Yes ____No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

__Yes __No	AIDS/HIV	__Yes __No	Anemia
__Yes __No	Arthritis, Rheumatism	__Yes __No	Artificial Heart Valves
__Yes __No	Artificial Joint	__Yes __No	Asthma
__Yes __No	Back Problems	__Yes __No	Bleeding abnormally, with extractions or surgery
__Yes __No	Blood Disease	__Yes __No	Cancer
__Yes __No	Chemical Dependency	__Yes __No	Chemotherapy
__Yes __No	Circulatory Problems	__Yes __No	Congenital Heart Lesions
__Yes __No	Cortisone Treatments	__Yes __No	Cough, persistent or bloody
__Yes __No	Diabetes	__Yes __No	Emphysema
__Yes __No	Epilepsy	__Yes __No	Fainting or dizziness
__Yes __No	Glaucoma	__Yes __No	Headaches
__Yes __No	Heart Murmur	__Yes __No	Heart Problems
__Yes __No	Hepatitis Type ___	__Yes __No	Herpes
__Yes __No	High Blood Pressure	__Yes __No	Jaundice

__Yes __No	Jaw Pain	__Yes __No	Kidney Disease
__Yes __No	Liver Disease	__Yes __No	Low Blood Pressure
__Yes __No	Mitral Valve Prolapse	__Yes __No	Nervous Problems
__Yes __No	Pacemaker	__Yes __No	Psychiatric Care
__Yes __No	Radiation Treatment	__Yes __No	Respiratory Disease
__Yes __No	Rheumatic Fever	__Yes __No	Scarlet Fever
__Yes __No	Shortness of Breath	__Yes __No	Sinus Trouble
__Yes __No	Skin Rash	__Yes __No	Special Diet
__Yes __No	Stroke	__Yes __No	Swollen Feet or Ankles
__Yes __No	Swollen Neck Glands	__Yes __No	Thyroid Problems
__Yes __No	Tonsillitis	__Yes __No	Tuberculosis
__Yes __No	Tumor or growth on head or neck	__Yes __No	Ulcer
__Yes __No	Venereal Disease	__Yes __No	Weight Loss, unexplained

Do you wear contact lenses? ___Yes___No

Women: Are you pregnant? ___Yes___No

Due Date _____ Are you nursing? __Yes__No Taking birth control pills? ___Yes___No

Medications

List any medications you are currently taking and the correlating diagnosis: _____

_____

_____

_____

Pharmacy Name _____

Phone (____) _____

Allergies

Are you allergic to any of the following?

__ Aspirin
__ Barbiturates (Sleeping pills)
__ Codeine
__ Iodine
__ Latex
__ Local Anesthetic
__ Penicillin
__ Sulfa

Other _____

_____

AQUILA DENTAL DESIGN

Dr. Sara Mosley, DDS
Family, Cosmetic and Invisalign Dentist

9915 East Bell Road, Suite 130
Scottsdale, AZ 85260

(480) 538 – 8264

saramosleydds@yahoo.com
www.saramosleydds.com

Because, you deserve a beautiful smile!

Our Services:

Cleaning & Exam

INVISALIGN *(clear braces)*
ZOOM! *(1 hour whitening)*
LUMINEERS
Tooth Colored Fillings
Porcelain Veneers
Crowns & Bridges
Implants & Dentures

24 Hour Emergency Service

Relaxed Atmosphere
Ultra-Comfort Chairs
Nitrous Sedation

We cater to special needs patients.

Adults and Children Welcome!

OPEN SATURDAYS!

*** Preferred provide of Dental Insurances*

Patient Consent Form: Use and disclosure of Health Information Protected Under HIPPA

Pursuant to the information contained in the Notice of Privacy practices, I give permission for the use and disclosure of Protected Health Information (PHI) in order to carry out Treatment, Payment, & healthcare Operations (TPO).

I am aware that I have the right to review the Notice of Privacy Practices prior to signing this consent. Should the Notice of Privacy Practices be revised, I am aware that I may obtain a copy of the revised form by contacting the Dental Director of this facility.

I give my consent for this organization to contact me by calling my home, or other designated location in order to leave a message (mechanically or with anther person) or to speak to me directly regarding any matter which will help with the conduct of treatment, Payment and healthcare Operations.

I herby consent to the use and disclosure of my PHI for the purpose of Treatment, Payment, and Health care Operations. This consent is good until revoked in writing, except to the entered that disclosures have been make in reliance upon my prior consent.

I hereby consent that photographs may be taken during my procedure to be used in a manner for dental programs developed on behalf of Aquila Dental Design. I give my permission for these photographs to be used for educational purposes. I understand that my name will not be published on any of these materials beyond documentation for my chart.

Services are provided without regards to sex, race, color, religion, national origin, or disability.

Patient Signature:_____**Date**_____

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Financial Arrangements And Dental Insurance

Welcome to Aquila Dental Design! We are committed to providing you with the best possible care. In order to achieve this goal, we need your assistance & understanding regarding our payment policy.

Payment for services is due at the time the services area rendered. We accept Cash, Checks, all major Credit Cards, Care Credit and Capital one/Dental fee plan.

As a courtesy to you, we will process your primary insurance claims if you will provide a completed insurance form to us. However, you must realize, that:

1.) Your insurance is a contract between you, your employer, and the insurance company. We are **NOT** a party to that contract.

2.) Not all services are covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. A few carriers reimbursement policies area based on an arbitrary "scheduled" of fees for specified services. These fees bear no relationship to the current standard of cost for care in this area, and area absolute in their structure.

3.) Some insurance companies do not pay or give alternative fee to resin fillings (white filling), and/or PFM (white crowns); therefore, you will be responsible for the charges.

4.) If your insurance company doesn't pay within 30 days, you will receive the bill.

5.) Co-payments are due at the time services are rendered.

6.) All charges are your responsibility.

7.) We expect you to show up for all your scheduled appointments. If you need to reschedule, we require 48 hours notice. If this notice is not given, we reserve the right to charge for broken appointment fee of **$35.00**.

Returned checks and balances older than 30 days are subject to additional collection fees and interest charges of 2.9% per month.

If you have any questions about the above information, please do not hesitate to ask. Thank you for your cooperation.

Patient signature _____ **Date**_____