Thank You for Selecting Our Dental Team

To help us meet all your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Patient Number _____

Name _____ Date _____

Soc. Sec. # _____ Birthdate _____ Cell Phone _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College _____ City _____ State _____ ☐ Full Time ☐ Part Time

Email Address _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SSN# _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit? _____

Do You Have Any Additional Insurance? ☐ Yes ☐ No If Yes, Complete the Following

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit? _____

Over Please

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	☐	☐
4. Have you ever taken Phen-Fen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you wearing contact lenses?	☐	☐

8. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other _____	☐	☐

	Yes	No
9. Are you allergic to or have you had any reactions to the following:		
Local Anesthetics (e.g. novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other _____	☐	☐
10. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

Patient Dental History

Name of Previous Dentist _____ Date of Last Exam _____

Previous Dentist's Location _____ Date of Last Cleaning _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials? If yes, date of placement _____	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and / or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent if minor)

Doctor's Comments _____

_____

_____ **Signature** _____ **Date** _____

REORDER # 0620339

DAMERON & TEAM

BRETT A.
DAMERON, D.D.S.

Member of: American Dental Association
Academy of General Dentistry
American Academy of Cosmetic Dentistry

FAMILY DENTISTRY
"Committed to Excellence"

12320 North 32nd Street, Suite 1
Phoenix, AZ 85032
Phone (602) 992-1384
Fax (602) 992-6104
drdameron@drdameron.com
www.drdameron.com

Disclosure Agreement

I _____ give permission
Print Name
to Dr. Dameron & Team to discuss my treatment and/or billing issues with the following people.

1. _____
2. _____
3. _____
4. _____
5. _____

Signature _____
Date _____

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Our Doctors & staff are very concerned about the cost of your dental needs & would like to address some current issues related to the cost of dental services in this office. Considerable care has been taken in setting up our fee schedule. We would like to assure you that the charges accurately reflect the skill & expertise required as well as quality of materials used to provide the best service for you. Our fees are comparable with fees of other dentists in the area that provide similar quality care.

If any insurance company indicates that our fees are above the "Usual & Customary", please understand that most dentist fees are above the rate which insurance companies choose to pay. We cannot and do not allow insurance companies to set or dictate fees or service we provide our patients. Our policy requires payment at time of service. As always, we do accept Visa, MasterCard, American Express and Discover.

If you have insurance you must pay your estimated portion at the time of service. As a courtesy we will file the claim with your insurance carrier. However, our agreement for payment is with you and NOT your insurance company. Payment to our office is neither contingent nor dependent upon your insurance.

There is a $25.00 service charge for all returned checks. There will be interest charged if your account becomes delinquent beyond 30 days. You understand that if you default on your payments, an outside collection agency will be used. You understand that you will be responsible for the collection fees of 45% of the outstanding balance. You also understand should suit be brought against you, you will be responsible for court costs and attorney fees.

I have read and understand my financial responsibilities under this policy.

_____ _____

Patient/Responsible Party Signature Date

Financial policy2010

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drdameron@drdameron.com
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Notice of Privacy Practices
Patient Acknowledgement of Receipt
(Patient May Refuse To Sign This Agreement)

Dr. Brett Dameron

This Healthcare Practice recognizes that every patient has the Right of Privacy concerning their personal health information. We make every effort to protect and preserve patient records in a manner that secures this information

By signing this Acknowledgement:
You are only confirming that you have received a copy of our Privacy Practices.

You do not give up any of your Rights and you may choose at some point in the future to provide more specific instructions for us to follow regarding your personal health information.

I have received a copy of this office's Notice of Privacy Practices:

Print name here: _____

Sign your name here: _____

Today's date: _____

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Important Medical Alert

A connection between **FOSAMAX** and other bisphosphonates, with a serious bone disease called Osteonecrosis of the Jaw (ONJ) has been found.

BISPHOSPHATES are commonly used in tablet form to prevent and treat osteoporosis in post-menopausal women, and older men. They are also used in the treatment of **PAGET'S DISEASE.** Stronger forms given orally or intravenously (I.V.) are commonly used in the management of advanced cancers including, but not limited to, lung cancer, breast cancer, prostate cancer, multiple myeloma and other metastatic cancers.

Have you **EVER** taken any of the following:
Oral Medications:

Y	N	Alendronate (Fosamax, Fosamax Plus)
Y	N	Clodronate (Bonefos,Ostac)
Y	N	Etidronate (Didronel)
Y	N	Ibandronate (Boniva)
Y	N	Pamidronate (Aredia)
Y	N	Risedronate (Actonel)
Y	N	Tiludronate (Skelid)
Y	N	Zoledronate (Zometa,Reclast) annual infustion

Y N Have you ever been treated for cancer with chemo therapy in the past? This applies even if the treatments was many years prior

Intravenous I.V., cemo therapy

Y	N	Clondronate (Bonefos)
Y	N	Pamidranate (Aredia)
Y	N	Zoledronate (Zometa)

If yes, When? _____

Prescribing Doctor Name & Phone#:

_____

_____

Signature _____

Print Name _____ Date_____