

Welcome to
Fletcher Heights Dental Care P.C
8272 W. Lake Pleasant Parkway, Suite 204
Peoria, AZ 85382
623-825-7833

Fletcher Heights Dental Care, PC
New Patient Questionnaire

In order for us to provide you with exceptional care, we would like to get to know you better. In our office, all of the following are important to us, however, we would like to know which is the most important to you.

- Function (being able to chew/eat)
- Comfort (being out of pain and staying there)
- Cosmetic (how your teeth look, I.C., color, shape, straight)
- Longevity (dentistry that lasts)

When considering having treatment, which of these would be of most concern to you:

- Fear
- Time
- Budget
- Trust
- No sense of urgency

What is the most important quality for you in a relationship with Dr. Prost?

When discussing your individual dental needs, do you prefer a detailed explanation or are you more interested in the bottom line?

Clinical Questions:

1. What about your smile makes you not want to smile or what would you change about your smile if you could? (Shade/color, shape, straighter, etc.)

2. Have you been told you grind your teeth or do you notice that you wake up with headaches?

Yes No

3. Do you wear any kind of an appliance? _____

4. Have you ever worn braces?

Are you interested in braces?

For Office Use Only

Assistant: _____ Date: _____

Patient Name: _____ Blood Pressure: _____

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New Patient Dental Intake Form

Patient Information

Name: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell/Home Phone: _____ Work Phone: _____ Email: _____

Sex: M F Marital Status: Single Married Divorced Separated Partnership Widowed

Employer or School: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Spouse, partner, or parent name: _____

Person to contact in case of emergency: _____ Phone: _____

How did you learn about our practice or whom may we thank for referring you? _____

Who is responsible for your account and payment? (if different from previous listing): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____ Birthdate: _____

Dental Insurance

Insurance Company: _____ Phone: _____

Subscriber's Social Security #: _____ Group#: _____ ID#: _____

Address: _____ City: _____ State: _____ Zip: _____

How much is your deductible?: _____ How much have you used?: _____ What is your annual Maximum? _____

Who's name is this insurance under? _____

Employer offering this insurance? _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance

Insurance Company: _____ Phone: _____

Subscriber's Social Security #: _____ Group#: _____ ID#: _____

Address: _____ City: _____ State: _____ Zip: _____

How much is your deductible?: _____ How much have you used?: _____ What is your annual Maximum? _____

Who's name is this insurance under? _____

Employer offering this insurance? _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Dental History

Reason for today's visit: _____

Date of last dental care visit: _____ Date of last dental x-rays: _____

Former Dentist's name: _____ Phone: _____

Check if you have any problem with the following?

- Bad breath Loose teeth or broken fillings Periodontal treatment Bleeding gums
 Sensitivity to any of the following: cold, hot, sweets Food collection between certain teeth
 Grinding teeth Clicking or popping jaw Sensitivity when biting Sores or growth in your mouth

How often do you floss?: _____ How often do you brush?: _____

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Medical History

Your Physician: _____ Date of last visit: _____

Have you ever taken any bone density medication Yes No If yes, when/ what _____

Have you had any serious illnesses or operations? Yes No If yes, describe: _____

Have you ever had a blood transfusion? Yes No If yes, give approximate dates: _____

Women: are you pregnant? Yes No Are you nursing? Yes No Are you taking birth control? Yes No

Check if you have or have had any of the following:

- | | | |
|--|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Radiation treatment |
| <input type="checkbox"/> Arthritis, rheumatism | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Respiratory disease |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Headaches | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Artificial joints, pins, etc. | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Bleeding abnormally | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Swelling of feet or ankles |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> HIV AIDS | <input type="checkbox"/> Tobacco use |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Congenital heart lesions | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pacemaker | |

List medications you are currently taking and the correlating diagnosis:

Medication	Diagnosis

Please list any allergies you may have:

Allergy	Allergy

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child has a change in my health.

Patient or Guardian Signature: _____ Date: _____

INFORMED CONSENT AND NOTICE TO ALL PATIENTS FOR SERVICES

I understand that the information is correct to the best of my knowledge. I authorize the dental staff to perform any necessary dental services, such as x-rays, study models, photographs, cleanings, fillings, crowns, local anesthesia and/or any other diagnostic aid deemed by the doctor to make a thorough diagnosis.

I also authorize the doctor and his employees for assistance when applicable to perform any and all forms of treatment, medication and therapy with my informed consent in connection with my diagnosis and treatment plan. Photos taken of my teeth may be used for marketing purposes, with the option to opt out at any time. Faces or other defining features are not shown on any public site, pamphlet, or poster.

Even though I may have dental insurance coverage, I understand payment for services rendered is my responsibility. I hereby authorize Dr. Prost to retain all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I also assign all insurance benefits directly to Dr. Prost for services rendered.

Financial Policy

1. It is our policy to make definite and clear financial arrangements prior to beginning any treatment. We are in-network and/or a participating provider with some insurance companies, but not all of them. We will help you to maximize your dental benefits in our office.
2. Our fees are reasonable and customary for quality of care in this area, but as different insurance companies use different fee schedules (which vary greatly) we may or may not fall within what they consider to be usual and customary. You are responsible for paying all charges not covered by your insurance company.
3. Please remember that insurance is a contract between you and the insurance company. Despite verification by phone or written pre-authorization, your carrier may still deny payment on a claim.
4. We accept cash, debit, Visa, Mastercard, Discover, American Express and CareCredit. There is also a \$35 fee for returned checks.
5. Often times patients find it to be convenient for them to keep a credit card on file for balances over 60 days to be charged to. Is this something you would like to do? YES/NO If yes, please provide CC# and Expiration Date below:
6. As a courtesy to our patients as well as our office staff, we require **2 business days notice for all changes to your appointment(s)** (Business hours are Monday-Friday 8am-5pm). For example if your appointment is on Monday, you must make any necessary changes before closing time (5pm) Thursday. Any changes made to an appointment without **2 business days notice** or a **no show/no call** will be subject to a charge of **\$50 for hygiene per hour and \$150 for Doctor per hour** that the appointment was scheduled. Please remember that our/your valuable time is reserved. Your cooperation with this policy is very much appreciated.
7. I understand that payment is due at time of service. If for any reason your account is turned over to an outside collection agency due to non-payment of your account balance, all collection agency fees and any additional costs associated with the collection of your account balance will be added to the total amount owed.
8. The parent or guardian who brings a child for an appointment is responsible for paying the patient portion and any prior balance at that visit.
9. If collection efforts are needed, I agree to pay all reasonable costs of collections without limitation, attorney's fees and court costs.

By signing below, I acknowledge:

1. I have read the above conditions of treatment and payment and agree to their content.
2. I have read, understand and accept the conditions of this financial policy. I have also received a copy of this policy for my own records (If requested).
3. I understand that I am financially responsible for all charges, whether or not paid by insurance.
4. I authorize Fletcher Heights Dental Care, PC to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I also authorize release of any information, including diagnosis and the records of any or examinations rendered to my dependent or me during the period of such care to third party payors and/or health practitioners.

If opted, I authorize Fletcher Heights Dental Care, PC to charge balances over 60 days to the credit card on file that I have provided above.

Patient Name (Please Print)

Signature of Fletcher Heights Dental Care, P.C Staff

Signature of patient, parent or guardian

Date

Michael A. Prost, DDC Fletcher Heights Dental Care, P.C

Fletcher Heights Dental Care, PC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name: _____ Telephone: _____

Email: _____

Section B: To the Patient-Please read the following statements carefully

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Notice provides a description of our treatment, payment activities and healthcare operations, of the uses of disclosures we may make of your protected health information. A copy of our Notice is available upon request. We do encourage you to read it carefully and completely.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting:

Contact Person: Dana
Telephone: 623-825-7833
Address: 8272 W. Lake Pleasant Pkwy, Ste 204 Peoria, AZ 85382

Right to revoke: You will have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance to this Consent before we received your revocation, and we may decline to treat you or to continue treating you if you revoke this Consent.

Section C: Additional Authorization

I hereby authorize Fletcher Height Dental Care, its staff and representatives, to share any and all dental and financial information with the following individual(s) in office or over the phone.

At this time I do not want to authorize anyone other than parent/guardian

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

SIGNATURE

I, _____, have had full opportunity to read and consider the contents and Consent from and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosures of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____