

Welcome to Desert Sun Smiles This confidential information will help us prepare for your visit.

NAME _____
Mr Mrs Ms Rev Dr

I prefer to be addressed as _____

Birthdate ___/___/___ SS# _____-____-_____

Address _____
_____ Zip _____

Single Married Divorced Widowed Separated

Home # _____ Work # _____

Cell # _____

E-Mail _____

Employer _____

Address _____

Occupation _____

We use an appointment reminder system that can send you convenient email, text messages and/or postcards. We may also call and if necessary leave brief voicemail messages.

If you would prefer NOT to receive routine reminders from us via certain methods, please indicate below:

No Text Messages No E-Mail No Cell Phone
 No Home Phone No Work Phone No Postcards

Whom may we thank for referring you to our office?

Family members seen as patients here:

Spouse's Name _____

Birthdate ___/___/___ Work # _____

Cell # _____

Employer _____

Address _____

Occupation _____

Account Information

I have Dental Insurance to cover a portion of my fees

Name on Account Self Spouse Other

Preferred Payment Arrangements (please check one)

Cash or personal check at time of service
 Visa, MasterCard, Amex or Discover at time of service
 CareCredit

Please check one box in each section:

<input type="checkbox"/> I currently have no dental or jaw pain or sensitivity.
<input type="checkbox"/> I currently have some dental or jaw pain or sensitivity.
<input type="checkbox"/> My mouth is very comfortable.
<input type="checkbox"/> My mouth is moderately comfortable.
<input type="checkbox"/> My mouth is uncomfortable.
<input type="checkbox"/> I am satisfied with the appearance of my teeth.
<input type="checkbox"/> I am curious about changing the appearance of my teeth.
<input type="checkbox"/> I am not satisfied with the appearance of my teeth.
<input type="checkbox"/> I am aware of current dental treatment that I need.
<input type="checkbox"/> I am not aware that I need any dental treatment.
<input type="checkbox"/> I think my present state of dental health is excellent
<input type="checkbox"/> I think my present state of dental health is good
<input type="checkbox"/> I think my present state of dental health is fair
<input type="checkbox"/> I think my present state of dental health is poor

Concerns I see about achieving or maintaining excellent dental health are:
(If you select more than one of the following, please number them in order of significance with #1 being that which is most significant for you at this time)

_____ I see no obstacles

_____ Time away from work or other obligations

_____ Fear of possible discomfort, pain or injections

_____ Fear because of past dental experiences

_____ The cost of treatment

_____ Other _____

My current **MEDICAL** health is:

Excellent Good Fair Poor
Are you under the care of a physician? No Yes

Physician Name _____

Office location _____

Office telephone _____

List all medications you take (prescription and over counter)

Have you ever had any of the following:

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> HIV / Aids | <input type="checkbox"/> Shingles | <input type="checkbox"/> Artificial Joint |
| <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Artificial Valve |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Epilepsy / Seizures |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Colitis | <input type="checkbox"/> Drug/Alcohol Dependence |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hemophilia / Bleeding |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Difficulty Breathing |

- Hospitalized _____
 High / Low Blood Pressure
 Blood Transfusion
 Severe or Frequent Headaches _____

For Women:

- Are you taking birth control pills No Yes
Are you pregnant No Yes
Are you nursing No Yes

NONE OF THE ABOVE APPLY TO ME

Are you allergic to, or have had difficulty with any of the following substances:

- | | | |
|--------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Dental Anesthetic |
| <input type="checkbox"/> Sulfa | <input type="checkbox"/> Erythromycin | |
| <input type="checkbox"/> Other Drugs | _____ | |

The information provided is accurate & complete to the best of my knowledge. I authorize the doctor to take X-rays, make study models, photographs, or other diagnostic materials deemed appropriate by the doctor to make a thorough diagnosis of my dental health condition. I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the services required for my dental health. I understand that the doctor will discuss treatment before it is initiated. I further authorize and consent that the doctor choose and employ such assistance as deemed fit.

Dr. Brady provides dental continuing education training to dentists & health care providers around the world, often using her patient's cases and clinical information to provide relevant educational content. Unless I check the box below, I give permission to publish or use in print or electronic media any of my clinical photographs, x-rays, diagnostic information and findings, in whole or in part for educational purposes only. I understand I may withdraw this permission at any time by notifying Dr. Brady in writing.

Do not use my clinical information for educational purposes

I understand that the responsibility for payment for professional services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless written financial arrangements have been made and signed by me. In the event of default I promise to pay interest on the indebtedness, together with any collection costs and attorney fees as may be required to effect collection.

All past due amounts are assessed 2% per month

SIGNED _____ **DATE** _____

Thank you for filling this form out completely. If you have questions regarding this form or any aspect of our dental practice please call us anytime.

**Desert Sun Smiles, LLC
Dr. Lee Ann Brady 623.939.4777**

Dental Insurance Information and Agreement

As a service to our valued patients WE SUBMIT TO ALL INSURANCE COMPANY PLANS AND FILE ALL INSURANCE CLAIMS FOR YOU ELECTRONICALLY.

A SIGNED AND COMPLETED INSURANCE FORM IS REQUIRED FOR OUR FILES

The responsibility of the insurance company is to you and it is important that you make sure that you are reimbursed properly. Fees for services provided to insured patients are the usual and customary fees charged to all patients for similar services. Your policy may base its allowance on a fixed fee schedule determined solely by your insurance company. The percentage of the fee paid may therefore be different than the percentage listed in your benefit booklet. Our office has developed fees based on services provided and do not *participate* with insurance carriers in determining appropriate fees. In deciding with whom she should participate, the doctor has selected YOU. We will do our very best to be certain that you receive all of the benefits due to you from your insurance carrier. If you have any questions please ask us.

I wish to have you file my claims electronically. I have read all above completely and agree to the arrangements as stated.

SIGNED _____ **DATE** _____