# ZAPATA DENTAL

**Will you please inform the dentist or the staff at the beginning of each new office visit if your Medical or Dental Conditions have changed since we last saw you? YES ☐ NO☐. Thank-You**

## Patient Information

Date: _____

Patient: _____

Address: _____

_____

City State Zip

I prefer to be called: ☐ Mr. ☐ Mrs.☐ Miss ☐ Other

Birthday: _____ Gender: F ☐ M ☐ Age _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS#_____-_____-_____

If patient is a minor, give parent's or guardian's Name: __

_____

_____

Occupation: _____

Employer: _____

Spouse's Name: _____

Spouse's Occupation_____

Spouse's Employer_____

Who may we thank for referring you?_____

_____

## Phone number

Home Phone_____CELL: _____

Work:_____ Ext_____

Spouse's Work_____

Best Time to reach you: _____

Family Physician's Name: _____

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

Name_____

Relationship_____

Home Phone_____

Work Phone_____

## Assignment And Release

I certify that I (or my dependent) have insurance coverage as Indicated and assign directly to this office all insurance benefits 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 doctor to release all information Necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ _____

Relationship to minor (if applicable) DATE:

## Dental Insurance

Who is responsible for this account? _____ SS#_____

Birthdate_____Relationship to patient: _____

Insurance Co._____Group#_____

Is patient covered by additional insurance? YES ☐ NO ☐ Group#_____

Subscriber's Name: _____ Insurance Co.: _____

# ZAPATA DENTAL

## 1 Dental History

Reason for today's visit _____

_____

Former Dentist _____

Date of last dental visit _____

Date of last dental x-rays _____

***Mark "Yes" or "No" to indicate if you presently have or previously had any of the following:***

| | | |
|---|---|---|
| Bad breath | Yes ☐ | No ☐ |
| Bite your lips or cheeks regularly | Yes ☐ | No ☐ |
| Bleeding gums | Yes ☐ | No ☐ |
| Blisters on lips or mouth | Yes ☐ | No ☐ |
| Chew on one side of mouth | Yes ☐ | No ☐ |
| Dry mouth | Yes ☐ | No ☐ |
| Food collection between the teeth | Yes ☐ | No ☐ |
| Grinding teeth | Yes ☐ | No ☐ |
| Gums swollen or tender | Yes ☐ | No ☐ |
| Jaw pain or tiredness | Yes ☐ | No ☐ |
| Mouth breathing | Yes ☐ | No ☐ |
| Orthodontic treatment | Yes ☐ | No ☐ |
| Pain around ear | Yes ☐ | No ☐ |
| Periodontal (gum) treatment | Yes ☐ | No ☐ |
| Sensitivity to cold | Yes ☐ | No ☐ |
| Sensitivity to hot | Yes ☐ | No ☐ |

***Have you experienced:***

| | | |
|---|---|---|
| Clicking or popping of the jaw? | Yes ☐ | No ☐ |
| Pain? (joint, ear, side of face) | Yes ☐ | No ☐ |
| Difficulty in opening or closing the mouth? | Yes ☐ | No ☐ |

How often do you floss? _____

How often do you brush? _____

| | | |
|---|---|---|
| Do you require antibiotics before dental treatment? | Yes ☐ | No ☐ |
| Are you currently in pain? | Yes ☐ | No ☐ |
| Have you ever had a serious / difficult problem associated with any previous dental work? | Yes ☐ | No ☐ |
| Do you like your smile? | Yes ☐ | No ☐ |
| Do you feel nervous about having dental treatment? | Yes ☐ | No ☐ |
| Have you ever had a bad experience in a dental office? | Yes ☐ | No ☐ |

If yes, please describe _____

_____

Is there anything else about having dental treatment that you would like us to know? _____

_____

_____

_____

## 2 Medical History

Your current physical health is:
☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? Yes ☐ No ☐
Please explain: _____

_____

Are you taking any prescription / over the counter drugs? Yes ☐ No ☐ Please list each one: _____

_____

_____

_____

_____

_____

_____

_____

Do you smoke or use tobacco in any other forms? Yes ☐ No ☐

**For Women:**

| | | |
|---|---|---|
| Are you taking birth control pills? | Yes ☐ | No ☐ |
| Are you pregnant? | Yes ☐ | No ☐ |
| Are you nursing? | Yes ☐ | No ☐ |

***Do you have or have you ever had any of the following diseases or medical problems?***

| | | |
|---|---|---|
| Abnormal Bleeding | Yes ☐ | No ☐ |
| Alcohol / Drug Abuse | Yes ☐ | No ☐ |
| Alzheimer's Disease | Yes ☐ | No ☐ |
| Anemia | Yes ☐ | No ☐ |
| Arthritis | Yes ☐ | No ☐ |
| Artificial Bones / Joints / Valves | Yes ☐ | No ☐ |
| Asthma | Yes ☐ | No ☐ |
| Blood Transfusion | Yes ☐ | No ☐ |
| Bruise Easily | Yes ☐ | No ☐ |
| Cancer / Chemotherapy | Yes ☐ | No ☐ |
| Colitis | Yes ☐ | No ☐ |
| Diabetes | Yes ☐ | No ☐ |
| Difficulty Breathing | Yes ☐ | No ☐ |
| Emphysema | Yes ☐ | No ☐ |
| Epilepsy | Yes ☐ | No ☐ |
| Fainting Spells | Yes ☐ | No ☐ |
| Frequent Headaches | Yes ☐ | No ☐ |
| Glaucoma | Yes ☐ | No ☐ |
| Hay Fever | Yes ☐ | No ☐ |
| Heart Problems | Yes ☐ | No ☐ |
| Heart Murmur | Yes ☐ | No ☐ |
| Hemophilia | Yes ☐ | No ☐ |
| Hepatitis | Yes ☐ | No ☐ |
| Herpes / Fever Blisters | Yes ☐ | No ☐ |
| High Blood Pressure | Yes ☐ | No ☐ |
| HIV+ / AIDS | Yes ☐ | No ☐ |
| Hospitalized for Any Reason | Yes ☐ | No ☐ |
| Joint Replacement | Yes ☐ | No ☐ |
| Kidney Problems | Yes ☐ | No ☐ |
| Liver Disease | Yes ☐ | No ☐ |
| Low Blood Pressure | Yes ☐ | No ☐ |
| Mitral Valve Prolapse | Yes ☐ | No ☐ |
| Nervous/Anxious | Yes ☐ | No ☐ |
| Pacemaker | Yes ☐ | No ☐ |
| Psychiatric/Psychological Care | Yes ☐ | No ☐ |
| Radiation Treatment | Yes ☐ | No ☐ |
| Rheumatic / Scarlet Fever | Yes ☐ | No ☐ |
| Seizures | Yes ☐ | No ☐ |
| Sinus Problems | Yes ☐ | No ☐ |
| Stroke | Yes ☐ | No ☐ |
| Thyroid Problems | Yes ☐ | No ☐ |
| Tuberculosis (TB) | Yes ☐ | No ☐ |
| Tumors or Growths | Yes ☐ | No ☐ |
| Ulcers | Yes ☐ | No ☐ |
| Venereal Disease | Yes ☐ | No ☐ |

Do you have or have you had any disease, condition, or problem not listed? Yes ☐ No ☐

Are you **allergic** to any of the following?

| | | |
|---|---|---|
| Aspirin | Yes ☐ | No ☐ |
| Codeine | Yes ☐ | No ☐ |
| Dental Anesthetics | Yes ☐ | No ☐ |
| Latex | Yes ☐ | No ☐ |
| Metals | Yes ☐ | No ☐ |
| Penicillin | Yes ☐ | No ☐ |
| Tetracycline | Yes ☐ | No ☐ |

Please list any other drugs/materials that you are allergic to: _____

_____

_____

## 3

**CERTIFICATION: I certify that the answers given are correct to the best of my knowledge.**

Signature _____ Date _____

**ZAPATA DENTAL** TEL: (480) 760-3433 (623)846-0575 2915 N. 59th Ave. Phoenix AZ 85033

# OFFICE POLICY

When you schedule an appointment, you are responsible for keeping that appointment. We understand there are considerations for not keeping your appointment. Therefore, we give you a courtesy call the day before to remind you of this appointment. You will be charged a $25.00 fee per NO SHOW or CANCELLATION without proper notice. A proper notice is 24 hours in advanced. It is our office policy. Due to this strict policy, it is your responsibility to make sure that we have good contact number/s. Thank you for your attention to this very important matter.

TELEPHONE NUMBER TO CONFIRM APPOINTMENT:_____

PATIENT NAME:_____

MINORS (UNDER THE AGE OF 18): We required an adult guardian to accompany a minor on his or her dental visit. We also require that a parent/guardian sign for financial responsibility if under the age of 18. That person will be liable for payment on the account. In divorce or child custody disputes, the person signing for responsible party will be held liable for payment. WE WILL ONLY BILL THE OTHER PARENTS INSURANCE WITH WRITTEN PERMISSION FOR THE ABSENT PARENT. NO EXCEPTIONS! _____
Initials

## Patients with Insurance

**You will receive services with the understanding that in the event your insurance coverage is not effective, you will be billed and held financially responsible for services rendered. Should your insurance company deny payment for any reason, including, but not limited to lack of pre-authorization, eligibility, policy plan limitation or exclusions, waiting periods, non covered expenses, coordination of benefits, clause of exceeding yearly maximums, you are responsible for payment in full when you receive our billing.**
**In the event your insurance company sends the reimbursement check directly to you, you must immediately turn over the endorsed check to our office to be applied to your balance for services rendered.** _____
**Initials**

## Payment Policy

In all cases, Zapata Dental patients agree to the following payment policies:

- Payment in full of the estimated patient portion of the fees is due no later than when services are rendered.
- For comprehensive treatment plans requiring multiple office visits, Zapata Dental requires a deposit of the total estimate patient portion of the fees at the start of treatment.
- Patient may, at their discretion, elect to pay in full, in advances for comprehensive treatment plans. Refunds for unused credit balances will be issued pursuant to Zapata Dental's refund policy.
- Patients are always responsible for amounts not covered by insurance, regardless of whether the original estimate includes an expected insurance benefit, unless prohibited by law, or unless Zapata Dental has a contractual agreement with the plan prohibiting all or a portion of such charges.
- In the event that payment is not made on this account and it is placed with a licensed collection agency, I/we agree to pay the fees of the collection agency. Should legal action also be necessary to collect the accounts balance, I/we agree to pay attorney's fees and court costs incurred for collection.

_____
**Initials**

## Refund Policy

No monetary refunds will be made. We could only apply it as office credit towards your account or towards a family members account at your request. _____
**Initials**

**By signing below I am acknowledging that I have read the above policy.**

_____ _____
**Patient/Parent/Guardian Signature** **Date**

# NOTICE OF PRIVACY PRACTICE

*Patient Acknowledgment of receipt*

**ZAPATA DENTAL**
TEL: (480) 760-3433
2915 N. 59th Ave.
Phoenix AZ 85033

The Healthcare Notice of Privacy Practices recognizes that every patient has the Right to 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 acknowledgment:

You are only confirming that you have received a copy of our privacy practices.

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

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

Print your name here:_____

Sign your name here:_____

Fill in today's date here:_____