Affinity Dental
21321 E Ocotillo Rd. #130 Queen Creek, AZ 85142 • 480-882-2300

Adult Dental Registration

Patient Information

Patient Name _____
Date of Birth _____ ☐ Male ☐ Female
Social Security # _____
☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other
Address _____
_____
_____
Phone:
Home _____ Work _____
Cell Phone _____
E-mail _____

May we use your email and/or cell phone number to send appointment reminders, confirm your appointments or other information regarding your dental care?

☐ Yes ☐ No

Employer/School _____

Emergency Contact

Name _____
Relationship to Patient _____
Home Phone _____ Cell Phone _____

How did you hear about Affinity Dental?

☐ Referral (their name) _____
☐ Mailing ☐ Social Media (Facebook, Instagram, etc.)
☐ Building Sign ☐ Yelp Online Review
☐ Website ☐ Google Online Review
☐ Insurance Company ☐ DemandForce Online Review
☐ Other _____

Primary Dental Insurance

Subscriber Name _____
Relationship to Patient _____
Date of Birth _____ SS/ID# _____
Address (if different from patient) _____
_____
_____
Subscriber's Employer _____
Insurance Company _____
Group # _____

Secondary Dental Insurance

Subscriber Name _____
Relationship to Patient _____
Date of Birth _____ SS/ID# _____
Address (if different from patient) _____
_____
_____
Subscriber's Employer _____
Insurance Company _____ Group # _____

Cosmetic and Special Services

Are you interested in a FREE consultation or information on any of the following services?

☐ Invisalign Teeth Straightening or Short Term Braces
☐ Lumineers/Veneers
☐ One hour in office instant teeth whitening
☐ Dental Implants
☐ Other _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Affinity Dental
(Name of Insurance Company)
and its associates all insurance benefits, if any, otherwise payable to me for service 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. Affinity Dental and its associates may use my health care information and may disclose such information to the above named company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

Signature of Patient or personal representative _____
Print name of Patient or personal representative _____
Relationship to Patient _____
Date _____

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Dental & Medical History Information

Dental History

Patient Name _____ Reason for today's visit _____

Former Dentist _____ City/State _____

Date of last dental visit _____ Date of last dental X-rays _____ How often do you brush? _____ Floss? _____

Please check all dental conditions that apply, past or present:

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Blisters on lips or mouth
- ☐ Burning sensation on tongue
- ☐ Chew on one side of mouth
- ☐ Cigarette/pipe/cigar/smoking
- ☐ Clicking or popping jaw
- ☐ Dry mouth
- ☐ Fingernail biting
- ☐ Food collection between teeth
- ☐ Foreign objects
- ☐ Grinding teeth
- ☐ Gums swollen or tender
- ☐ Jaw pain
- ☐ Jaw tiredness
- ☐ Lip or cheek biting
- ☐ Loose teeth/broken filling(s)
- ☐ Mouth breathing
- ☐ Mouth pain, brushing
- ☐ Orthodontic treatment
- ☐ Pain around ear
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores/growths in mouth

Medical History

Physician's Name _____ City/Phone# _____/(__)__-_____ Date of last visit _____

Please check all that apply:

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Joints
- ☐ Asthma, Use Inhaler: ☐ Yes ☐ No
- ☐ Blood Disease
- ☐ Cancer, Type _____
- ☐ Chemical Dependency
- ☐ Chemotherapy, when _____
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, persistent/bloody
- ☐ Diabetes
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis, type _____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Nervous Problems
- ☐ Pacemakers
- ☐ Psychiatric Care
- ☐ Weight Loss/Gain
- ☐ Radiation Therapy, when _____
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Special Diet
- ☐ Stroke
- ☐ Swollen Feet/Ankles
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor on Head/Neck
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Other _____

Have you ever taken a medication that contains bisphosphonates? This includes brands such as Actonel, Aredia, Boniva, Didronel, Fosamax, Zometa. ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Medications: (List any medications you are currently taking and the correlating diagnosis)

_____

Allergies: (Please check all that apply)

☐ Aspirin ☐ Codeine ☐ Erythromycin ☐ Latex ☐ Local Anesthetic ☐ Metals ☐ Penicillin ☐ Sulfa ☐ Tetracycline ☐ Other _____

I certify to the accuracy of the above statements regarding my medical and dental history.

_____ Signature of patient, parent guardian or representative

_____ Print name of patient, parent guardian or representative

_____ Date

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Financial Policies & General Consent for Treatment

Please read through the following information. After reading, please provide your signature at the bottom indicating that you fully understand these policies. This form must be signed in order to proceed with your scheduled appointment. If you have any questions or concerns, please ask to speak with the Office Manager. Thank you!

- **Insurance:** We are happy to bill both primary and secondary insurances as a ***courtesy*** for our patients. It must be understood that each patient is ultimately responsible for the cost of services rendered. We will do our best to estimate accurate insurance coverage and patient portions due; however, the contractual agreement is between you and your insurance company. If the insurance company does not pay the full amount anticipated, the patient is responsible for the difference. Payment is expected within 30 days of receiving a statement.
- **Patient Payment:** The patient portion due for services rendered is expected **at the time of service** unless *previous* arrangements have been made. We accept cash, checks, money orders, and all major credit cards.
- **Financing:** We have financing options available through Care Credit. If you have an interest in these options, please consult with the Office Manager prior to the date of scheduled treatment.
- **No Shows/Missed Appointments:** We request notice to cancel or reschedule an appointment at least 24 hours in advance. If appropriate notice is not given, a charge of $25 may be assessed to the patient's account. For appointments scheduled for longer than 1 hour, an additional $25 will be charged for each hour missed, i.e. $50 for a 2 hour appointment, $75 for a 3 hour appointment.
- **Refunds for Unfinished Treatment:** If a patient decides to discontinue treatment after it has been started, a full refund will not be given. Individual circumstances may be discussed with the Office Manager and/or Dentist.
- **Credits on an Account:** If an insurance company pays more than anticipated creating a credit for the patient, we are happy to either refund the patient or leave the credit on the account to be applied toward future treatment.
- **Balances.** Balances unpaid after 30 days from the date of billing are subject to a finance charge at a rate of 3% per month (37% per annum).
- **Collections:** On occasion, after repeated attempts to collect a balance due, we may need to turn an account over to a collections agency. Should this occur, it is agreed that the financially responsible party listed below shall pay all finance charges, collection cost, attorneys fees, and any other costs incurred to enforce collection.
- **Returned Checks.** A $35 fee will apply for all checks returned for insufficient funds or closed accounts, and may prevent us from accepting checks as a form of payment for your dental treatment in the future.
- **Right to Discontinue Treatment:** I understand that Affinity Dental has the right to discontinue my care for any appropriate reason, such as excessive missed appointments or lack of compliance. The patient or patient's representative agrees to accept full responsibility for pursuing alternate professional dental care. All records are the property of Affinity Dental. Records/x-rays may be duplicated upon written request and a reasonable fee.
- **General Dentistry Informed Consent for Treatment** includes but is not limited to: Extracting teeth, Dental implants, Dentures or partial dentures, Local anesthesia and medicines, Restoring teeth with fillings or crowns, bridges, veneers, inlays, or onlays, Root canals. I understand that specific informed consents may be made available for any or all of the above procedures. I understand that dental treatment contains no guarantees, warranty, or assurance of success.
- **Risks:** All dental procedures have certain risks; including possible side effects from medicines used. The risks include, but are not limited to: allergic reactions, cuts/abrasions, tenderness/bruising, and tooth sensitivity.

I hereby give permission for diagnosis and /or treatment at Affinity Dental for myself or minor child below. I acknowledge that I have read the above information and have been provided with an opportunity to ask questions about its content. I accept full financial obligation for the services received by the dental professionals at Affinity Dental.

Patient Name: _____

Financially Responsible Person: _____

Signature of Financially Responsible Person: _____ Date: _____

Insurance and Preventative Services Reminder

We would like you to be aware that, as a courtesy, we will always do our best to verify your insurance for coverage at the time of service. HOWEVER, due to the growing number of insurance companies and policies, there is **no guarantee of benefits** and your insurance can retract verification at any time. It is YOUR responsibility to verify that you are eligible for your dental services. Any claims not paid by your insurance in a timely manner (within 90 days) is your responsibility. **The contract for insurance is between you and your insurance company.**

A common myth regarding dental insurance is that dental cleanings, exams and x-rays are always "free." While many policies cover these services at no out-of-pocket cost to you, many companies are reducing this coverage by either making a portion of the cost patient responsibility or enforcing limitations for how many times they will cover a certain service, such as an exam. We make significant efforts to obtain these details and to notify you when possible; however, **policies can change without notice**. **Ultimately, the contract is between you and your insurance company.** This means that there may be times when there will be a balance due, even after a cleaning, x-rays or an exam.

X-rays are the most effective way for our doctors to diagnose what is occurring in your mouth. X-rays help to see the developing mouth of children, to see structures or masses that may not be visible through examination, and to verify location of active decay or infection. *We will seek to bill your insurance for your x-rays, but we will not determine what x-rays are needed for proper diagnosis solely based on what your insurance will cover.*

We are proud to provide new state-of-the art x-ray imaging with 3D CT technology! These are called conebeam images and are ideal for specific types of oral health issues. Not every patient will need or receive a conebeam image. When provided, **the fee for a conebeam image is $250 and is due at the time of service.**

Please rest assured that the team at Affinity Dental wants you to receive the most from your insurance coverage and the best possible diagnosis and care available!

Thank you,

Affinity Dental

_____ _____

Signing here indicates acknowledgement of the above information Date

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Acknowledgement of Receipt of Notice of Privacy Practices

****You May Refuse to Sign This Acknowledgment****

If the patient is under 18 years of age, a parent or legal guardian must sign.

I, _____, have received a copy of this office's Notice of Privacy Practices.
{Please Print Patients Name}

_____
{Signature of Patient or Parent/Legal Guardian}

_____
{Date}

Pre-medication, billing statements and appointment reminders:
I am authorizing this office to call me and remind me to take my pre-medication before my dental appointment or provide notice of a billing statement or appointment. They may leave a message for me regarding this information at any number that I have supplied to them. They may leave a message on any answering machine, voice mailbox or with whoever answers the telephone. I also authorize this office to remind me of this information on any reminders that the office will mail or email to me.

Our office requests that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital and insurance company. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

Authorization to Release Information to Family Members and/or Friends

Many of our patients allow family members such as their spouse, parents or others such as friends to call and request appointment times, rescheduling of appointment times for the patient, to go over insurance benefits or financial/billing information, and/or the request results of tests and procedures. Under the requirements for H.I.P.P.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have this information released to family members and/or friends you must sign this form. Signing this form will only give consent to release appointment times, rescheduling of patient appointment times, to go over insurance benefits, and/or the results of tests and procedure to the family members and/or friends indicated below. This consent form will not allow our office to release any other information about you. However, you have the right to revoke this consent, in writing prior to expiration of that one year, except where we have already made disclosures in reliance on your prior consent. I authorize this office to speak with the below listed individuals regarding my appointment times, rescheduling of appointment times, to go over insurance benefits or financial/billing information, and/or the results of tests and procedures.

1. **Individual Name**_____ **Relation to Patient:** _____
2. **Individual Name**_____ **Relation to Patient:** _____

_____
{Signature of Patient or Parent/Legal Guardian} (DATE)