Estrella Mountain
DENTISTRY

700 N. Estrella Parkway #100
Goodyear, AZ 85338
Office (623) 474-6095
Fax (623) 474-6175
estrellamountaindental@gmail.com
www.estrellamountaindentistry.com

PATIENT INFORMATION FORM

WELCOME

The benefits of a happy, healthy smile are immeasurable!
Our goal is to help you reach and maintain maximum oral health.

- PLEASE FILL OUT THIS FORM COMPLETELY. -

The better we communicate, the better we can care for you.

1 ABOUT YOU

Name _____

Preferred Name _____ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Birthdate / / Age_____ SS# _____

Address _____

City _____State_____ Zip_____

Email _____

Home#_____ Work#_____

Mobile# _____ Fax# _____

How did you hear about us?_____

Other family seen by us? _____

Last visit date _____

Employer _____

Employer# _____ How long there? _____

2 ACCOUNT INFO

PERSON RESPONSIBLE FOR ACCOUNT

Name _____ Relation _____

Home#_____ Work#_____

Mobile# _____ Fax# _____

Email _____

Billing Address_____

City _____State_____ Zip_____

3 SPOUSE INFO

Name _____

Home#_____ Work#_____

Mobile# _____ Birthdate / /

Email _____

4 INSURANCE

Provider Name_____

Provider Address _____

City _____State_____ Zip_____

Group# _____

Insured's Name _____ Relation _____

Insured's Birthdate / / Insured's ID#_____

Insured's Employer _____

Insured's Ph# _____

SECONDARY INSURANCE

Provider Name_____

Provider Address _____

City _____State_____ Zip_____

Group# _____

Insured's Name _____ Relation _____

Insured's Birthdate / / Insured's ID#_____

Insured's Employer _____

Insured's Ph# _____

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PATIENT INFORMATION FORM - CONT'D

5 Medical History

Your current physical condition ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription/over-the-counter or herbal supplement drugs? ☐ Yes ☐ No

Please list each one _____

_____

Have you ever taken Bisphosphonates? ☐ Yes ☐ No

(Known as Fosamax, Actonel, etc.) if yes, when? _____

FOR WOMEN ONLY

Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Y	N	Abnormal Bleeding	Y	N	Hepatitis
Y	N	Alcohol/Drug Abuse	Y	N	Herpes/Fever Blisters
Y	N	Anemia	Y	N	High Blood Pressure
Y	N	Arthritis	Y	N	HIV+/AIDS
Y	N	Artificial Bones, Joints or Valves	Y	N	Kidney Problems
Y	N	Asthma	Y	N	Liver Disease
Y	N	Blood Transfusion	Y	N	Lupus
Y	N	Cancer/Chemotherapy	Y	N	Osteoporosis
Y	N	Colitis	Y	N	Pacemaker
Y	N	Congenital Heart Defect	Y	N	Psychiatric Care
Y	N	Diabetes	Y	N	Radiation Treatment
Y	N	Difficulty Breathing	Y	N	Seizures
Y	N	Emphysema	Y	N	Sickle Cell Disease
Y	N	Epilepsy	Y	N	Sinus Problems
Y	N	Fainting Spells	Y	N	Stroke
Y	N	Frequent Headaches	Y	N	Thyroid Problems
Y	N	Glaucoma	Y	N	Tuberculosis (TB)
Y	N	Heart Attack	Y	N	Ulcers
Y	N	Heart Surgery	Y	N	Venereal Disease
Y	N	Hemophilia			

Please list any medical condition not mentioned above:

_____

Have you been hospitalized in the last 2 years? Please list why:

_____

Do you wish to discuss any problems not listed ? ☐ Yes ☐ No

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Y	N	Aspirin	Y	N	Jewelry/Metals
Y	N	Codeine	Y	N	Latex
Y	N	Dental Anesthetics	Y	N	Penicillin
Y	N	Erythromycin	Y	N	Tetracycline
Y	N	Sulfa			

Please list any allergies not mentioned above:

_____

6 Medical Info

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

_____

Physician's Name _____

Phone# _____ Last Visit Date / /

IN THE EVENT OF AN EMERGENCY, WHO SHOULD WE CONTACT?

Name _____ Relation _____

Home#_____ Work# _____

7 Dental History

Why have you come to the dentist today?_____

_____

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 or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Your current dental health is? ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

How many times a week do you use floss? _____

How many times a day do you brush? _____

Type of toothbrush bristles? ☐ Hard ☐ Medium ☐ Soft

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WELCOME PAGE - Q&A

WE WARMLY WELCOME YOU.

To better serve you, please take just a couple minutes to answer the following questions. Thanks!

Please check any of the following problems that apply to you:

- ☐ Sensitivity (hot, cold or sweet)
- ☐ headaches, earaches, neck pain
- ☐ teeth or fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen, or irritated gums
- ☐ loose, tipped, or shifting teeth
- ☐ Bad breath

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

- ☐ Dentures
- ☐ Partial Dentures
- ☐ Periodontal (gum) treatments

Please share the following approximate dates:

Your last cleaning_____

Your last oral cancer screening_____

Your last complete x-rays _____

Who was your previous dentist?

Name: _____

City:_____State: _____

Phone: _____

What are the most important things to you about your smile and dental health? _____

_____

_____

Do you smoke or use chewing tobacco? ☐ Yes ☐ No

If yes, how much?_____

And, for how long? _____

If you could change your smile, would you:
(Please check all that apply)

- ☐ Make your teeth whiter
- ☐ Make your teeth straighter
- ☐ Close spaces between teeth
- ☐ Replace black metal fillings with tooth-colored restorations
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

On a scale of 1 to 5, with 5 being the highest rating:
(Please circle the numbers that best applies)

How important is your dental health to you?

1 2 3 4 5

How would you rate your current dental health?

1 2 3 4 5

Where do you want your dental health care to be?

1 2 3 4 5

Why did you leave your previous dentist?

_____

_____

What is the most important thing to you about your dental visit today? _____

_____

_____

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PATIENT ACKNOWLEDGEMENTS

8 Disclaimer

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

In the event that payment in full for charges incurred is not made, I agree to pay off all costs of collection including a 50% collection fee, attorney fees and court costs.

Signature _____

Date _____

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

9 Privacy Practices

Estrella Mountain Dentistry
ACKNOWLEDGEMENT OF NOTICE
OF PRIVACY PRACTICES
****You may refuse to sign this acknowledgement****

I, _____, understand that Estrella Mountain Dentistry abides by the HIPAA Law and will protect the privacy of my personal information.

Please Print Name _____

Signature _____

Date _____

FOR OFFICE USE ONLY
We attempted to obtain written acknowledgement for the receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign.
____ Communication barriers prohibited us from obtaining acknowledgement.
____ An emergency situation prevented us from obtaining acknowledgment.
____ Other (Please Specify)

Thank You!

We appreciate you for filling out this form completely. It will allow us to serve you more effectively.
If you have a question at any time, please call us. ***We are happy to help.***