New River - Anthem Family Dentistry

WELCOME

PATIENT INFORMATION

Name _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Social Security Number _____ Birthdate _____

Check Appropriate Box ❑ Minor ❑ Single ❑ Married ❑ Other

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name_____ Employer _____ Work Phone _____

If Patient is a Student, Name of School/College _____ City _____ State _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone # _____

INSURANCE

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security Number _____ Date Employed _____

Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____

Address _____ City _____ State _____ Zip _____

INTERNET

INTERNET AUTHORIZATION

If you would like to be able to log onto our website www.anthemdentistry.com to see your account, upcoming appointments and more, please provide us with your _____.
E-mail Address

I Authorize New River Anthem Family Dentistry to make my account information available on the internet for my use only.

_____ _____
Signature Date

PRIVACY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's notice of Privacy Practices
Patients name

_____
Please Print Patient or Parent name

_____ _____
Signature Date

Medical & Dental History

DENTAL HISTORY

Reason for Today's Visit: _____

Date of Last Dental Visit: _____ Date of Last X-Rays: _____

How do you feel about the condition of your teeth? _____

How do you feel about the color of your teeth? _____

MEDICAL HISTORY

Medical Physician's Name: _____ Address: _____

Have you been under the care of a physician/hospital in the last 2 years? _____ For? _____

Please list any major surgeries or illnesses you've had in the last 2 years: _____

_____

Women: Are you pregnant or nursing? ❑ Yes ❑ No Are you taking hormones or birth control? ❑ Yes ❑ No

Do you smoke or use tobacco? _____ How long? _____

Have you ever been told by a doctor you need to take medication prior to dental treatment? ❑ Yes ❑ No

Are you now taking or have you taken any prescription medications during the past year? ❑ Yes ❑ No

If Yes, please list: _____

_____

Are you allergic or sensitive to any drugs or medications? ❑ Yes ❑ No If yes, please list: _____

Please check (✓) **Yes or No** for each item.

Yes	No		Yes	No		Yes	No	
❑	❑	Abnormal Blood Pressure	❑	❑	Diabetes	❑	❑	Organ Transplant
❑	❑	Allergies	❑	❑	Epilepsy or Seizures	❑	❑	Polio
❑	❑	Anemia	❑	❑	Fainting	❑	❑	Prolonged Bleeding
❑	❑	Angina	❑	❑	Glaucoma	❑	❑	Prolonged Cough
❑	❑	Arthritis	❑	❑	Heart Disease	❑	❑	Psychiatric Treatment
❑	❑	Artificial Heart Valves/Pacemaker	❑	❑	Heart Murmur	❑	❑	Radiation Therapy
❑	❑	Artificial Joints	❑	❑	Hepatitis	❑	❑	Rheumatic Fever
❑	❑	Asthma	❑	❑	Herpes	❑	❑	Sickle Cell Anemia
❑	❑	Blood Transfusions	❑	❑	HIV	❑	❑	Stroke
❑	❑	Cancer	❑	❑	Jaundice	❑	❑	Thyroid Disease
❑	❑	Chemical Dependency	❑	❑	Kidney Disease	❑	❑	Tuberculosis
❑	❑	Chemotherapy	❑	❑	Latex Allergy	❑	❑	Ulcers or Sores
❑	❑	Congenital Heart Lesions	❑	❑	Liver Disease	❑	❑	Venereal Disease
						❑	Other: _____	

AUTHORIZATION & RELEASE

I have read the above questions and the answers I have given are true and to the best of my knowledge, I am indicating my consent for routine dental procedures such as X-rays, cleanings, fillings, crowns, and local anesthesia, as needed by signing below.

_____ _____

Patient or Parental Signature Date

_____ _____

Dentist's Signature Date

Provider Review:	
Date	Initials

Patient Identification:

Name: _____ DOB: _____

Darren L. Flowers, D.M.D.

Anthem Medical Plaza
3618 W. Anthem Way, Ste. #D-132
Anthem, AZ 85086

Patient Name:_____ D.O.B.:_____

Responsible Party (If not patient)

Name:_____ Phone:_____

Address:_____ D.O.B.:_____

City/State/Zip:_____ S.S.N.:_____

FINANCIAL AGREEMENT
Payment in full for all charges is required at time of visit, unless prior arrangements have been made.

INSURANCE FILING
You, the patient are ultimately responsible for payment in full on your account, not the insurance company. We do, however, file dental insurance claims as a courtesy to our patients. We can only make *estimates* regarding your insurance benefits based on the information provided by you and the insurance company. In the event your insurance company does not pay as much as expected, the remaining balance is due and payable immediately by you, the patient.

ASSIGNMENT OF INSURANCE BENEFITS
I/we hereby assign directly to Dr. Flowers insurance benefits otherwise payable to me/us. I/we hereby authorize the release of any information relating to any claims. I/we understand I/we are financially responsible for charges not paid by this assignment.

DELINQUENT ACCOUNTS
All delinquent accounts (30 days or older) are subject to reasonable service charges and/or legal interest rates.

COLLECTION PROCEEDINGS
In the event your account is turned over to a collection agency for non-payment or other delinquency, you will be responsible for payment of any collection costs **(30%)** and/or attorney fees, in addition to the balance owed. Any account turned over to a collection agency forfeits any past special fees and/or discounts. Such special fees and/or discounts will be reversed and you will be responsible for payment of regular fee for procedures at the time of service.

FAILED APPOINTMENTS
Failed appointments (less than 24 hours notice) are a significant contributor to rising heath care costs. Individuals who fail to show for a confirmed appointment may be assessed a $50.00 fee.

I have completely read and understand the contents of this agreement. I agree to comply with all policies.

Patient/Responsible Party Signature Date

_____ _____