Michael S. Crockett , DDS & Rick Jacobi , DDS

Phone : 480.981.0203 . Fax : 480.924.5211
31 South 63rd Street • Suite 5 • Mesa. Arizona 85206
www.CrockettDentalAZ.com

Welcome TO OUR PRACTICE

Date

PATIENT INFORMATION

First Name ________________ **MI** ______ **Last Name**________________

Preferred Name________________ **Birthday** ____________ **Home Phone (___)** ________

Summer Address ________________________________

City ________________________________**State** __________ **Zip** __________

Winter Address ________________________________

City ________________________________ **State** __________ **Zip** __________

Sex ☐**M** ☐**F** **Status** ☐**Married** ☐**Single** ☐**Minor** **SS#** ________________

Cell Phone ________________ Preferred contact for appointments ________________

Email ________________________________

Employer ________________________ **Employer Phone (___)** ____________

Employer Address ______________ **City** ____________ **State** ________ **Zip** _____

Spouse or Parent's name ______________ **Employer** __________ **Work Phone (___)** ______

Whom may we thank for referring you ? ________________________________

Person to contact in case of emergency ________________________ **Phone (___)** ____________

DENTAL INSURANCE INFORMATION

Name of Insured ________________________ **Relation to Patient** ________________

Birth Date ________________________ **SS # or ID#** ________________

Insurance Company ________________________**Phone#** ________________

Employer________________________________

SECONDARY DENTAL INSURNCE

Name of Insured ________________________ **Relation to Patient** ________________

Birth Date ________________________ **SS # or ID#** ________________

Insurance Company ________________________**Phone#** ________________

Employer________________________________

Reason for today's visit ____

Is there anything about your smile you don't like? ______________________________

Are you currently experiencing any of the following:

☐ Bad Breath	☐ Broken Teeth	☐ Hot Sensitivity
☐ Bleeding Gums	☐ Broken Fillings	☐ Sweet Sensitivity
☐ Loose Teeth	☐ Tooth Pain	☐ TMJ Discomfort
☐ Sore Gums	☐ Cold Sensitivity	☐ Teeth Grinding

Medical History

Primary Physicians name ____________________________ **Phone#** ____________

Are you under the care of a Specialist Physician (i.e. Cardiologist etc.)? ☐ Yes ☐No

Physicians name __________________________________ **Phone#** ____________

Have you taken or are you taking a bisphosphonate drug i.e. Fosamax, Actonel, Boniva?☐Yes ☐No

Check ☑ if you have had any of the following: **Allergies:**

			Allergies
☐ Anemia	☐ Cardiac stent	☐ Kidney disease	☐ Aspirin
☐ Exceesive bleeding	☐ Prostetic heart valve	☐ Liver disease	☐ Local anesthetic
☐ Blood disease	☐ History of Endocarditis	☐ Epilepsy	☐ Barbiturates
☐ Circulatory disease	☐ Congenital heart disease	☐ Artificial joints, pins, etc.	☐ Penicillin
☐ High blood pressure	☐ Heart transplant	☐ Tobacco habit	☐ Codeine
☐ Cardiac bypass	☐ Mitral valve prolapse	☐ Drug dependency	☐ Iodine
☐ Pacemaker	☐ Congestive heart failure	☐ Tuberculosis	☐ Other antibiotics
☐ Hepatitis A B C	☐ Stroke	☐ Fainting	☐ sulfa
☐ HIV / Aids	☐ Diabetes Type1 Type 2	☐ cancer	☐ Latex
☐ Asthma	☐ Respiratory disease	☐ Chemotherapy	☐ Other: __________
☐ COPD		☐ Radiation	__________
			__________

List medications you are currently taking including over the counter and dietary or herbal supplements

__________	__________	__________
__________	__________	__________
__________	__________	__________
__________	__________	__________

Have you ever had a serious illness or operation? ☐ Yes ☐No

If yes, please describe ____

Approximate date: ____

(Women) Are you pregnant? ☐ Yes ☐No **If yes, which trimester** ______________

To the best of my knowledge the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I have a condition not mentioned on this form.

______________________________ ______________

Signature of patient, parent, or guardian. **Date:**

______________________________ ______________

Printed name **Relationship**

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Financial Policy

Thank you for choosing Crockett Dental for your dental care. We are committed to assuring your treatment is successful. The following is a statement of our Financial Policy, which we require that you read and sign prior to any treatment. Please understand this Financial Policy is enforced to keep costs at a reasonable level, thus preventing frequent increases. This also allows us to concentrate on what we do best... Taking care of your dental health.

Full payment is due at the time of service.

We accept cash, check, and most major credit cards.

Interest free financing is available with credit approval for treatment through Care Credit. Please inquire at front desk for more information.

Insurance:

We may accept assignment of insurance benefits: however, we do require deductibles and co-payments to be paid at the time of service. The balance is your responsibility until paid in full. Your insurance policy is a contract between you and your insurance provider; we are not a party to your contract nor are we responsible for procedures that are not covered for any reason. We must have complete and up to-date insurance information in order to bill your insurance company on your behalf. In the event that your insurance company has not paid their portion within 60 days, the balance will be billed to you and payment will be expected.
(Initial) ___________________

Billing Charges:

A billing charge will be applied to any account which has a balance 45 days past due. This monthly fee will equal to 18% APR or a minimum of $5.00. (Initial) ___________________

Collection Fees:

Accounts that remain unpaid after 45 days may be turned over to our internal collection department. These collection efforts will incur collection fees internally that may total up to 50% of the account balance. When an account becomes 90 days past due, collection action may be taken outside of our dental office. In this event, you will be responsible for all collection and legal fees.
(Initial) ___________________

Missed Appointments:

Unless cancelled at least 24 hours in advance, there will be a $50.00 charge for broken appointments. Please help us to serve you an other patients more efficiently by keeping scheduled appointments. (Initial) ___________________

Returned Checks:

If a check is returned unpaid, there will be a $35.00 charge and checks will no longer be accepted.
(Initial) ___________________

I, the undersigned, assume financial responsibility as stated above and responsibility for all collection and legal fees if any account becomes past due. I have read, understand, and agree to this financial policy.

X ____   **_______________**

Signature of Responsible Party   **Date**

X ____

Printed Name of Responsible Party

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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

____
Please Print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the acknowledgement**
- ☐ **An emergency situation prevented us from obtaining acknowledgement**
- ☐ **Other (Please Specify)**

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