



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 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 INSURANCE

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:

- | | | |
|--|---|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Broken Teeth | <input type="checkbox"/> Hot Sensitivity |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Broken Fillings | <input type="checkbox"/> Sweet Sensitivity |
| <input type="checkbox"/> Loose Teeth | <input type="checkbox"/> Tooth Pain | <input type="checkbox"/> TMJ Discomfort |
| <input type="checkbox"/> Sore Gums | <input type="checkbox"/> Cold Sensitivity | <input type="checkbox"/> 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:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cardiac stent | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Prosthetic heart valve | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Local anesthetic |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> History of Endocarditis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Barbiturates |
| <input type="checkbox"/> Circulatory disease | <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Artificial joints, pins, etc. | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart transplant | <input type="checkbox"/> Tobacco habit | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Cardiac bypass | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Drug dependency | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Other antibiotics |
| <input type="checkbox"/> Hepatitis A B C | <input type="checkbox"/> Stroke | <input type="checkbox"/> Fainting | <input type="checkbox"/> sulfa |
| <input type="checkbox"/> HIV / Aids | <input type="checkbox"/> Diabetes Type1 Type 2 | <input type="checkbox"/> cancer | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Respiratory disease | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> COPD | | <input type="checkbox"/> 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



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

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 and 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



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

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)

