623-551-6300
www.MajesticDentistry.com

42104 N. Venture Dr., Suite B134
Anthem, AZ 85086

Welcome to Majestic Dentistry

We are honored that you have chosen our practice. Please help us get acquainted with you.

First Name_____Middle Initial_____Last Name_____Date_____

I prefer to be called_____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Street Address:_____Apt/Ste #_____

City_____ State _____ Zip Code _____

Home Phone # ( )_____Cell # ( )_____Work # ( )_____

Email Address:_____Date of Birth_____Age_____

Who may we thank for referring you to our practice?_____

What is your Business or Occupation?_____

What do you like to do for fun (Hobbies/Interests)_____

Spouse/partner's name_____Do you have children? Yes ☐ No ☐ If so, How many_____

Please list the names and ages of your children.

_____ Age_____ _____ Age_____ _____ Age_____

_____ Age_____ _____ Age_____ _____ Age_____

Please list the names and ages of your grandchildren.

_____ Age_____ _____ Age_____ _____ Age_____

_____ Age_____ _____ Age_____ _____ Age_____

Do you have pets? ☐ Yes ☐ No What type? ☐ Dog ☐ Cat ☐ Bird ☐ Other_____

Please list the names and types of pets you own.

_____ Type_____ _____ Type_____ _____ Type_____

_____ Type_____ _____ Type_____ _____ Type_____

Briefly, please tell us the reason for your first visit with us._____

DENTAL HISTORY

Have you ever experienced any adverse reaction to past dental care? ☐ Yes ☐ No

If yes, please explain_____

When was your last visit to a dentist?_____ Name of previous dentist?_____

What did you like most about your last dentist?_____

What did you least like about your last dentist?_____

What made you decide to leave your previous dentist?_____

How often do you visit the dentist to have your teeth cleaned? ☐ 3 mo. ☐ 6 mo. ☐ 1 yr. ☐ Longer

How often do you brush? _____x a day How often do you floss?_____

On a scale from 1 to 10, with 10 being completely healthy and ideal, how would you rate your oral health?

Please circle. 1 2 3 4 5 6 7 8 9 10

How important is it to you to keep your teeth healthy and looking good for your lifetime?

☐ Extremely important ☐ Somewhat important ☐ Not that important

On a scale from 1 to 10, with 10 being extremely fearful and nervous, please rate your level of fear and/or anxiety regarding your dental care.

Please circle 1 2 3 4 5 6 7 8 9 10

If you could change anything about your smile or your teeth, what would it be? Please check all that apply.

☐ Whiter ☐ Straighter ☐ Close Spaces ☐ Replace dark fillings with natural looking fillings
☐ Even out ☐ Size or shape ☐ Replace missing teeth ☐ Replace partial or full dentures

Are you experiencing any of the following: Please check all that apply.

☐ Clicking, popping or locking jaw ☐ Grinding or clenching ☐ Jaw pain ☐ Loose teeth
☐ Periodontal (gum) disease ☐ Sensitivity to Hot/Cold ☐ Sensitivity when biting
☐ Tension Headaches ☐ Awaken with awareness of your teeth/jaw ☐ Broken/loose fillings
☐ Sensitivity when brushing ☐ Smoker or Tobacco User ☐ Bad breath ☐ Bleeding gums
☐ Too much of my gums show when I smile

MEDICAL HISTORY

Have you ever needed to take or told that you needed to take antibiotics prior to your dental appointments? ☐ Yes ☐ No

Please rate your general health. ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you currently under a physician's care? ☐ Yes ☐ No Date of most recent physical exam_____

Physician Name_____ Physician Phone #_____

Have you ever had an allergic reaction to any of the following? Please check all that apply.

☐ Latex ☐ Penicillin ☐ Local Anesthetic ☐ Codeine ☐ Aspirin ☐ Tylenol ☐ Ibuprofen ☐ Other_____

Do you have or have you ever had any of the following? Please check all that apply.

☐ Heart Problems ☐ Artificial Prosthesis (Heart Valve, Hip or Knee Replacement) ☐ Digestive Disorders
☐ Chemotherapy ☐ Mitral Valve Prolapse ☐ Diabetes ☐ Emotional Problems
☐ Arthritis ☐ HIV/AIDS ☐ Psychiatric Treatment ☐ Heart Murmur
☐ Epilepsy, Convulsions, Seizures ☐ Viral Infections or Cold Sores ☐ High Blood Pressure
☐ Stroke ☐ Hepatitis (Type_____) ☐ Alcohol Dependency ☐ Prolonged Bleeding
☐ Hay Fever ☐ Cancer ☐ Drug Dependency ☐ Asthma
☐ Sinus Congestion ☐ Radiation Therapy ☐ Anti-depressant medication ☐ Rheumatic Fever
☐ Eating Disorder ☐ Thyroid Disease

WOMEN: Are you pregnant? ☐ Yes ☐ No Are you taking birth control Pills? ☐ Yes ☐ No

Please list all medications you are currently taking and reason for taking them.

Medication_____ For_____ Medication_____ For_____

Medication_____ For_____ Medication_____ For_____

Medication_____ For_____ Medication_____ For_____

Medication_____ For_____ Medication_____ For_____

Please describe any current medical treatment you are undergoing or any impending surgical procedures._____

EMERGENCY CONTACT INFORMATION: Name:_____ Phone:_____

RESPONSIBLE PARTY INFORMATION: Name:_____ Phone:_____

Social Security #_____ Driver Lic #_____

DENTAL INSURANCE/PLAN INFORMATION: Insurance Company Name_____

Policy Holder's Name_____ DOB_____

Policy Holder's Employer _____

Policy Holder's Social Security #_____

Group #_____ Subscriber ID #_____

Patient Responsibility Agreement

- I fully understand that I am financially responsible for any and all charges regardless of the outcome of my insurance. My insurance coverage is a relationship that I have with my insurance company and Majestic Dentistry has no part of that relationship. My insurance company does not guarantee benefits or payments and because of this, it is my responsibility to know my insurance coverage and benefits. Majestic Dentistry cannot guarantee any coverage or payments made by my insurance company and assume no responsibility regarding my insurance benefits or coverage.
- Cash, personal checks, Mastercard, Visa, American Express, Discover and Care Credit are all acceptable forms of payment. All payments and/or estimated copayments are required in full at the time of service.
- Any returned checks are subject to a $35.00 processing fee and must be resolved prior to scheduling future appointments. Only cash, credit cards or Care Credit will be accepted after a second occurrence.
- I understand if my balance remains unpaid, I will be responsible for any collection fees and/or legal fees associated with non-payment, including interest charges of 1.5% per month on my outstanding balance.
- I understand that my appointments are reserved exclusively for me and real costs are associated with this time. It is my responsibility to provide a minimum of 2 business days notice if I am unable to keep my appointment. Failure to do so may result in a $100 late cancelation fee.
- I hereby consent to the use of anesthetics, sedatives, photography and x-rays.
- I hereby consent, if I give a testimonial, to the use of my image and statements, and all audio, video and photographic recordings of my image and statements in any promotional material relating to Majestic Dentistry.

Signature of Patient/Guardian _____ Date: _____

If patient is a minor,

Signature of Parent/Guardian_____ Date_____

Our Patients with Insurance

I am aware that Majestic Dentistry will, as a courtesy to me, call my insurance company and obtain a breakdown of my benefits and submit all claim forms on my behalf. I understand Majestic Dentistry will act as an advocate on my behalf and will wait up to a maximum of 30 days for reimbursement from my insurance carrier. By deferring my payment, I agree to keep a credit card on file and Majestic Dentistry will contact me in advance before charging my card for any unpaid balance.

Card Type: Visa MasterCard American Express Discover Debit Card

_____ _____ _____

Card Number Expiration Date 3-Digit Code

Majestic Dentistry

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, **Majestic Dentistry** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to **Majestic Dentistry** Notice of Privacy Practices for a more complete description of such use and disclosures.

Majestic Dentistry reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Majestic **Dentistry**, 42104 N. Venture Ct. Suite B134, Anthem, Arizona 85086.

With my consent, **Majestic Dentistry** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care.

With my consent, **Majestic Dentistry** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders cards and patient statements.

With my consent, **Majestic Dentistry** may e-mail or text me to notify me of my appointments. I have the right to request that **Majestic Dentistry** restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to **Majestic Dentistry** use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **Majestic Dentistry** may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____
Patient's Name

_____ _____
Print Name of Patient or Legal Guardian Date