



Hello and a heartfelt welcome to our practice!

We appreciate the trust you have shown in us by selecting our office to care for your dental needs. We will make every effort to see that your dental visit is as comfortable as possible.

Your dental concerns come first with us. That is why we stay abreast of new dental techniques and continually improve our professional skills. Most important, we are sensitive to the feelings of our patients and encourage open communication about dental care.

On your first visit with us, you can expect a thorough oral examination including necessary x-rays. Please bring in your last set of Full Mouth X-rays, if you have a copy, if they are not of diagnostic quality, or if they are more than one year old, we will take new ones during your examination. Unless you have serious periodontal problems you will have a preventive prophylaxis or "teeth cleaning." We will discuss with you how you can help prevent dental disease through good health habits, and administer an oral cancer exam. We will listen carefully to your dental concerns and attempt to answer all of your questions thoroughly.

Unless an emergency comes up, you can expect us to be on time (We appreciate your being prompt also.) Enclosed you will find our health questionnaire. Please complete it at your convenience and bring it with you to your first visit. If you have dental insurance, you will want to bring your insurance information as well. You will also find our Appointment Policy, information on CareCredit, Our Promise to Our Patients and a map to our office.

We look forward to meeting you. If you have an emergency or if you have any questions, please feel free to call us at 480.829.8200.

Sincerely yours,

Stacy D Tracy DDS,
Roxane M Huber DDS,
and our whole staff



Name: _____ Age: _____ Birth Date: _____ Sex F M

Address: _____ Apt#: _____ City: _____ State _____ Zip: _____

Phone (Home):(____) _____ Work (____) _____ Ext: _____

Cell Phone () _____ E-mail address _____

Occupation: _____ Social Security No.: _____

Spouse's Name: _____ Parent's Name: _____
(If Minor)

Whom may we thank for this referral? _____

The following information is essential for this office to provide dental care in a manner that is compatible with your general health.

Physician: _____ Office Phone: _____

Name of nearest relative not living with you: _____ Phone:(____) _____

Address: _____ Apt#: _____ City: _____ State: _____ Zip: _____

Are you under any medical treatment now, during the appointment? Yes No
 Are you taking any medication? Yes No
 Are you allergic to any medication, local anesthetic or material (such as nickel) resulting in hives, asthma, etc.? Yes No
 Have you ever had any major operations?..... Yes No
 Have you had any complications after teeth extractions such as prolonged bleeding? Yes No
 Have you ever had radiation therapy or chemotherapy? Yes No
 Do you use or have you ever used tobacco products? Yes No
 Would you like to know what options are available to you to help you have a more attractive smile? Yes No

Do you have or have you ever had:

Mitral Valve Prolapse	Yes	No	Liver Disease	Yes	No	Tuberculosis	Yes	No
Heart Condition	Yes	No	Blood Transfusions	Yes	No	Anemia	Yes	No
High/Low Blood Pressure	Yes	No	Hepatitis/Jaundice	Yes	No	Epilepsy	Yes	No
Do you have a Pacemaker	Yes	No	Nervous Disorder	Yes	No	Diabetes	Yes	No
Artificial Joint/Heart Valves	Yes	No	Respiratory Disease	Yes	No	Asthma	Yes	No
Cortisone-Steroid Treatment	Yes	No	Heart Murmur	Yes	No	Rheumatic Fever	Yes	No
Tumor or Malignancy	Yes	No	Scarlet Fever	Yes	No	Venereal Disease	Yes	No
Thyroid Problem	Yes	No	Kidney Disease	Yes	No	AIDS/HIV Positive	Yes	No
Arthritis	Yes	No	Blood Disease	Yes	No	Are you Pregnant?	Yes	No

If yes, delivery date _____

Date of last dental visit _____ Were x-rays taken at that time _____ Were your teeth cleaned at that time _____

Do you have an immediate dental problem _____ If so, where _____

I acknowledge that the above information is correct to the best of my knowledge and any change in my health status should be reported to this office as soon as possible. I have read and understand the information on both sides of this form.

Patient Signature _____ Date _____
(or legal guardian)

Doctor's Signature _____ Date _____



Complete The Following:

Person responsible for Account: _____

SSN: _____ Date of Birth: _____

Employer: _____

Address: _____ Phone:(_____) _____

Dental Insurance Company: _____

Subscriber Number: _____

Group Number: _____ Single or Family Policy: _____

Spouse's Employer: _____

Address: _____ Phone:(_____) _____

Dental Insurance Company: _____

Subscriber Number: _____

Group Number: _____ Single or Family Policy: _____

Please remember that no insurance company attempts to cover all dental costs. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amounts, co-insurance, or any other balance not paid for by your insurance company.

We know questions can arise on insurance matters. We encourage you to discuss such questions with our business office staff. We will be happy to help you receive the maximum benefits; however, the agreement of the insurance company to pay for your dental care is a contract between you and the insurance company.

Financial Responsibility: I understand that I will be expected to pay in full for services at time of treatment. I further agree to pay all finance charges, collection costs, attorney fees, and other costs that may be incurred to enforce collection of any amounts outstanding. (Note: A fee of \$25 or 33 1/3% (which ever is greater) will be added to any past due accounts turned over to an outside collection agency.) If your account is sent to collection you will be dismissed as a patient of this practice.

Patient Signature _____ Date _____
(or legal guardian)



Appointment Policy

We schedule our dental appointments very carefully to assure all of our patients are seen promptly, and that sufficient time is allocated for each procedure. We do this because we value and respect our patient's time and desire to provide the best treatment possible. In order to remain on schedule, we request that you arrive on time for your appointments.

Occasionally, emergencies arise which may cause us to run over into your appointment. Every effort will be made to inform you of this, if this situation arises. We appreciate your understanding, as someday you or a family member may be in need of emergency dental care.

TWO BUSINESS DAYS NOTIFICATION IS REQUIRED TO AVOID A CANCELLATION CHARGE. THE MINIMUM FEE IS \$75.00 FOR A LATE CANCELLATION OR NO SHOW. We require notification by noon Thursday for appointments scheduled the following Monday.

I have read and understand the above.

Signed _____



Our Promise To Our Patients

We promise to remain current on the latest dental treatments, medications, and protocols through conferences, continuing education, research and publications.

We promise to respect your concerns and answer your questions with courtesy and professionalism.

We promise to be considerate of your time, and will endeavor to see you within a reasonable time of your scheduled appointment unless there is a dental emergency, which may delay your visit.

We promise to be sensitive to the fact that your dental needs are both uncomfortable and inconvenient to your normal lifestyle.

We promise to offer you the same degree of focused attention that we provide to each of our patients and allow the time necessary to address your dental problems thoroughly.

We promise to help answer any questions you may have about payment, insurance, medications, and treatment.

We promise to make every effort to make your visit to our office efficient, productive, and friendly.

We promise to do our part to make your visit as comfortable as possible and to make you feel welcome at all times.



Did you know that our office offers “No Interest” and “Extended Payment” Plans through CareCredit?

What is CareCredit?

CareCredit is a flexible patient/client payment program, specifically designed for healthcare expenses, that makes it easier for you to get the treatment or procedures you want and need. CareCredit is ideal for co-payments, deductibles, treatment and procedures not covered by insurance, and can be used at over 35,000 practices nationwide.

How can CareCredit help me get the treatment or procedure I want?

CareCredit lets you begin your treatment or procedure immediately—then pay for it over time with low monthly payments that are easy to fit into your monthly budget.

With CareCredit, you pay no up-front costs, no pre-payment penalties and no fees. Plus, CareCredit is a revolving credit line for additional treatment or add-on charges, without the need to re-apply

If you are interested;

- please visit their website (www.carecredit.com) for immediate approval,
- call our office before your visit for pre-approval, or
- ask our Front Office staff for more information when you visit the office.

2210 South Mill Avenue, Suite 3, Tempe, Arizona 85282

www.StacyTracyDDS.com

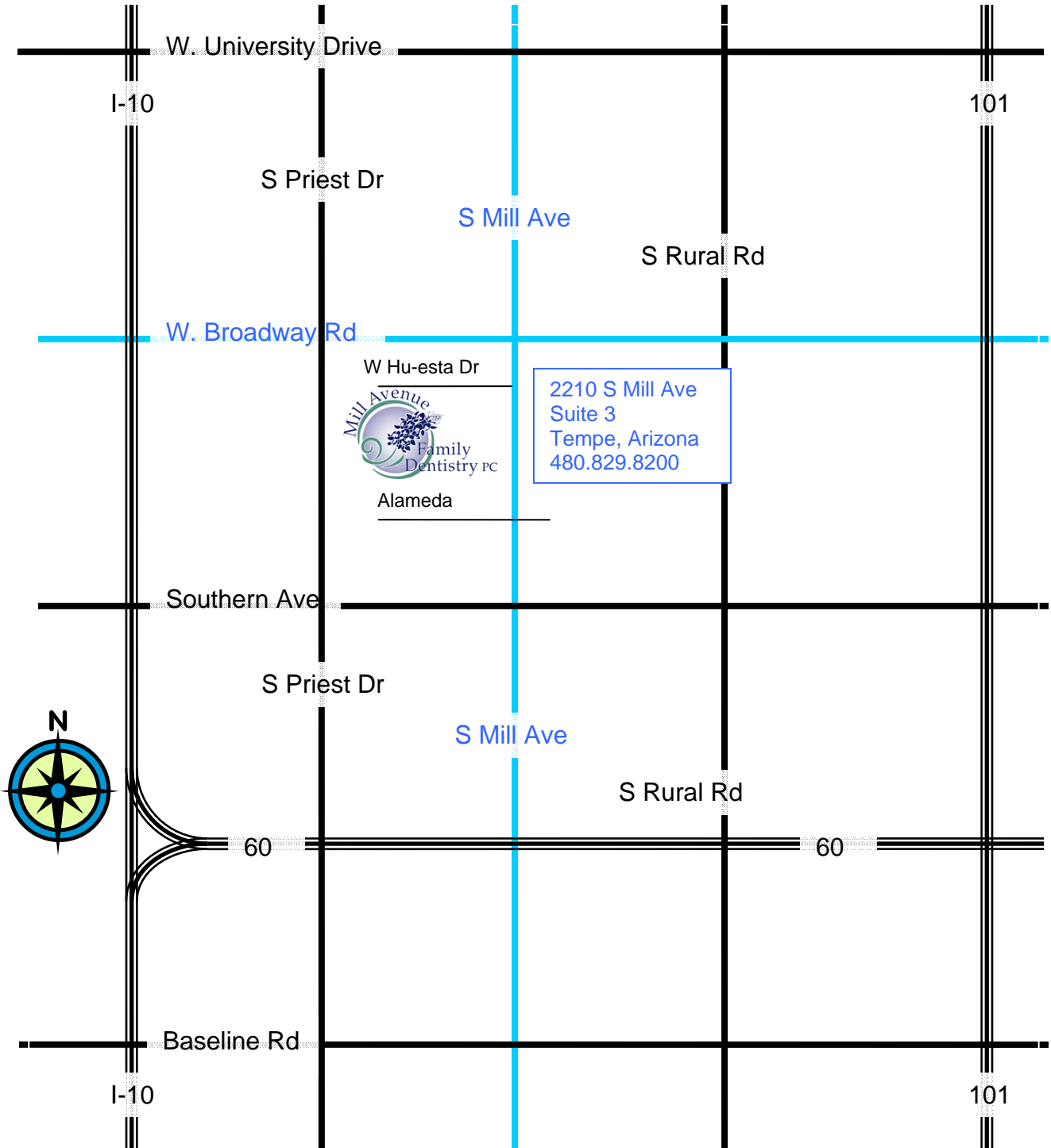
www.RoxaneHuberDDS.com

www.MillAveFamilyDentistry.com

480.829-8200



Map to Dental Office



2210 S Mill Ave
Suite 3
Tempe, Arizona
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