



14441 W. McDowell Rd. #B106 • Goodyear, AZ 85395
Office | (623) 536-3264 • Fax | (623) 536-7385
Email | info@estrellafallsdentistry.com

PATIENT INFORMATION FORM

WELCOME

At Estrella Falls Dentistry, your dental health & smile are our top priorities. We are dedicated to providing you with the personalized, gentle care that you deserve.

- PLEASE FILL OUT THIS FORM COMPLETELY. -

The better we communicate, the better we can care for you.

1 ABOUT YOU

Name _____

Preferred Name _____ Male Female

Single Married Divorced Widowed Separated

Birthdate / / Age ____ SS# _____

Address _____

City _____ State _____ Zip _____

Email _____

Home# _____ Work# _____

Mobile# _____ Fax# _____

How did you hear about us? _____

Other family seen by us? _____

Last visit date _____

Employer _____

Employer# _____ How long there? _____

3 SPOUSE INFO

Name _____

Home# _____ Work# _____

Mobile# _____ Birthdate / /

Email _____

4 INSURANCE

Provider Name _____

Provider Address _____

City _____ State _____ Zip _____

Group# _____

Insured's Name _____ Relation _____

Insured's Birthdate / / Insured's ID# _____

Insured's Employer _____

Insured's Ph# _____

2 ACCOUNT INFO

PERSON RESPONSIBLE FOR ACCOUNT

Name _____ Relation _____

Home# _____ Work# _____

Mobile# _____ Fax# _____

Email _____

Billing Address _____

City _____ State _____ Zip _____

SECONDARY INSURANCE

Provider Name _____

Provider Address _____

City _____ State _____ Zip _____

Group# _____

Insured's Name _____ Relation _____

Insured's Birthdate / / Insured's ID# _____

Insured's Employer _____

Insured's Ph# _____



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PATIENT INFORMATION FORM - CONT'D

5 MEDICAL HISTORY

Your current physical condition Good Fair Poor

Are you taking any prescription/over-the-counter or herbal supplement drugs? Yes No

Please list each one _____

Have you ever taken Bisphosphonates? Yes No
 (Known as Fosamax, Actonel, etc.) if yes, when? _____

FOR WOMEN ONLY

Are you taking birth control pills? Yes No

Are you pregnant? Yes No

Are you nursing? Yes No

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Y N	Abnormal Bleeding	Y N	Hepatitis
Y N	Alcohol/Drug Abuse	Y N	Herpes/Fever Blisters
Y N	Anemia	Y N	High Blood Pressure
Y N	Arthritis	Y N	HIV+/AIDS
Y N	Artificial Bones, Joints or Valves	Y N	Kidney Problems
Y N	Asthma	Y N	Liver Disease
Y N	Blood Transfusion	Y N	Lupus
Y N	Cancer/Chemotherapy	Y N	Osteoporosis
Y N	Colitis	Y N	Pacemaker
Y N	Congenital Heart Defect	Y N	Psychiatric Care
Y N	Diabetes	Y N	Radiation Treatment
Y N	Difficulty Breathing	Y N	Seizures
Y N	Emphysema	Y N	Sickle Cell Disease
Y N	Epilepsy	Y N	Sinus Problems
Y N	Fainting Spells	Y N	Stroke
Y N	Frequent Headaches	Y N	Thyroid Problems
Y N	Glaucoma	Y N	Tuberculosis (TB)
Y N	Heart Attack	Y N	Ulcers
Y N	Heart Surgery	Y N	Venereal Disease
Y N	Hemophilia		

Please list any medical condition not mentioned above: _____

Have you ever been hospitalized for any reason? Please list why: _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Y N	Aspirin	Y N	Jewelry/Metals
Y N	Codeine	Y N	Latex
Y N	Dental Anesthetics	Y N	Penicillin
Y N	Erythromycin	Y N	Tetracycline

Please list any allergies not mentioned above: _____

6 MEDICAL INFO

Are you currently under the care of a physician? Yes No

Please explain: _____

Physician's Name _____

Phone# _____ Last Visit Date / /

IN THE EVENT OF AN EMERGENCY, WHO SHOULD WE CONTACT?

Name _____ Relation _____

Home# _____ Work# _____

7 DENTAL HISTORY

Why have you come to the dentist today? _____

Has your doctor told you that you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

Have you ever had a serious/difficult problem associated with any previous dental work? Yes No

Do you or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Yes No

Your current dental health is? Good Fair Poor

Do you like your smile? Yes No

Do your gums ever bleed? Yes No

How many times a week do you use floss? _____

How many times a day do you brush? _____

Type of toothbrush bristles? Hard Medium Soft



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WELCOME PAGE - Q&A

WE WARMLY WELCOME YOU.

To better serve you, please take just a couple minutes to answer the following questions. Thanks!

Please check any of the following problems that apply to you:

- Sensitivity (hot, cold or sweet)
- Headaches, earaches, neck pain
- Teeth or fillings breaking
- Grinding or clenching teeth
- Bleeding, swollen, or irritated gums
- Loose, tipped, or shifting teeth
- Bad breath

Do you have or have you had any of the following?

- Dentures
- Partial Dentures
- Periodontal (gum) treatments

Please share the following approximate dates:

Your last cleaning _____

Your last oral cancer screening _____

Your last complete x-rays _____

Who was your previous dentist?

Name: _____

City: _____ State: _____

Phone: _____

What are the most important things to you about your smile and dental health? _____

Do you smoke or use chewing tobacco? Yes No

If yes, how much? _____

And, for how long? _____

If you could change your smile, would you:

(Please check all that apply)

- Make your teeth whiter
- Make your teeth straighter
- Close spaces between teeth
- Replace black metal fillings with tooth-colored restorations
- Repair chipped teeth
- Replace missing teeth
- Replace old crowns that don't match
- Have a smile makeover

On a scale of 1 to 5, with 5 being the highest rating:

(Please circle the numbers that best applies)

How important is your dental health to you?

1 2 3 4 5

How would you rate your current dental health?

1 2 3 4 5

Where do you want your dental health care to be?

1 2 3 4 5

Why did you leave your previous dentist?

What is the most important thing to you about your dental visit today? _____



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PATIENT ACKNOWLEDGEMENTS

8 DISCLAIMER

I understand that the information I have given today is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my medical & insurance status. I also understand that this information will be held in the strictest of confidence. I authorize the dental team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Since payment is due in full at the time of treatment (unless other arrangements have been approved), I am responsible for any amount not covered by my insurance. For all patient balances that become older than 90 days, I agree to pay a late charge of 18% (per annum) added to the balance of the account. Outstanding balances may be sent to a collections agency; I agreed to pay all costs associated with collections and attorney fees if suit be instituted hereunder. I understand that a returned check will result in a \$30 fee. If I need to reschedule an appointment, I will do everything within my power to give at least a 24 hour notice. I realize that failure to do so may result in a \$25 fee.

Signature _____ Date _____

Please feel free to discuss any questions or concerns you may have regarding our policies. We feel honored that you have chosen us.

9 PRIVACY PRACTICES

Jay Suaverdez, D.D.S.

ACKNOWLEDGEMENT OF NOTICE
OF PRIVACY PRACTICES

****You may refuse to sign this acknowledgement****

I, _____, understand that Dr. Suaverdez's Office abides by the HIPAA Law and will protect the privacy of my personal information.

Please Print Name _____

Signature _____

Date _____

FOR OFFICE USE ONLY

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

- Individual refused to sign.
- Communication barriers prohibited us from obtaining acknowledgement.
- An emergency situation prevented us from obtaining acknowledgment.
- Other (Please Specify)

THANK YOU!

We appreciate you for filling out this form completely. It will allow us to serve you more effectively.