7777 N. 43rd Avenue, Phoenix, AZ 85051
623-937-0267, FAX 623-847-3737

PATIENT REGISTRATION

YOU

LAST NAME FIRST M.I. NICKNAME

ADDRESS CITY, STATE ZIP

HOME PHONE CELL *EMAIL

BIRTHDATE AGE SOCIAL SECURITY NUMBER

DRIVER'S LICENSE # STATE *PLEASE PRESENT YOUR DRIVER'S LIC. FOR VERIFICATION*

OCCUPATION EMPLOYER'S NAME

EMP. ADDRESS EMP. PHONE FAX #

CHILD

LAST NAME FIRST M.I. NICKNAME

ADDRESS CITY, STATE ZIP

HOME PHONE DATE OF BIRTH SOCIAL SECURITY NUMBER

SCHOOL GRADE

INSURANCE

INSURANCE COMPANY GROUP NUMBER EMPLOYER NAME

INSURED'S NAME DATE OF BIRTH RELATIONSHIP TO PATIENT

INSURED'S ID # INSURED'S SOCIAL SECURITY #

SECONDARY INSURANCE COMPANY GROUP NUMBER EMPLOYER NAME

INSURED'S NAME DATE OF BIRTH RELATIONSHIP TO PATIENT

INSURED'S ID # INSURED'S SOCIAL SECURITY #

EMERGENCY CONTACT

NAME RELATIONSHIP

ADDRESS PHONE #

PERSON FINANCIALLY RESPONSIBLE FOR YOUR ACCOUNT

*YOU __________ YOUR SPOUSE__________ OTHER____________

NAME ADDRESS PHONE

RELATIONSHIP TO PATIENT SOCIAL SECURITY # DRIVER'S LICENSE #

OCCUPATION EMPLOYER'S NAME

EMP. ADDRESS EMP. PHONE FAX #

HOW DID YOU HEAR OF US?

FRIEND OR FAMILY__________________________________

VALPAK COUPON____POSTCARD____YELLOW PGS____INTERNET____ SIGN ____ OTHER__________________________

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ____

Are you on a special diet? ◯ Yes ◯ No ____

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No   Taking oral contraceptives? ◯ Yes ◯ No   Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: ____

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

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Breathing Problem	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pace Maker	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No	Yellow Jaundice	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No		

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: ____

Comments: ____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ____ DATE ____

Alvin C. Matthews, DDS, PC
FAMILY & COSMETIC DENTISTRY

7777 N. 43rd Avenue, Phoenix, AZ 85051
623-937-0267 www.SmilesByDrMatthews.com

INFORMED CONSENT and FINANCIAL POLICY

I understand that the information I have given today is correct to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in any medical status. I authorize the dental staff to perform any necessary dental services, such as x-rays, study models, photographs or any other diagnostic aid deemed appropriate by the doctor to make a thorough diagnosis. I also authorize the doctor (and his employees for assistance when applicable) to perform any and all forms of treatment, medication and therapy with my informed consent in connection with my diagnosis and treatment plan.

Payment is required on the day of your visit. Any discounts or coupons are void unless payment is made on the day of service. We accept cash, personal check or major credit card (Visa, MasterCard, Am Ex, Discover). We also offer the option to arrange financing for services through outside companies.

We do our best to estimate the patient portion of your bill and that estimated amount is due at the time of your treatment. Any amount left owing after insurance has paid will be billed to you immediately and is due within 10 days of the statement. Balances left after 30 days will incur an 18% APR service charge. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collections fees. If you have any questions about this policy, please ask one of our staff members before you receive treatment.

We also reserve the right to charge for appointments cancelled or broken without 24 hour notice at a rate of $50 per appointment, or $50 per hour which ever is greater. **Receiving payment at the time of service and keeping your appointment helps keep our costs and thus our fees down.*

________________________________ ________________

Patient/Parent or Guardian Signature Date

IF YOU HAVE DENTAL INSURANCE, THEN PLEASE SIGN BELOW:

PATIENT AUTHORIZED SIGNATURE FORM

The undersigned, hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits, for services rendered or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

We do accept all Preferred Provider Organization (PPO) insurance plans, but are not IN-NETWORK with all of them. We are still very happy to file on your PPO as an OUT-OF-NETWORK provider, but the patient is responsible for any difference between our fee and the amount insurance pays. Many times, there is not much difference between IN-NETWORK and OUT-OF-NETWORK coverage. A large number of our patients who are OUT-OF-NETWORK realize that choosing the best dental treatment available for them is worth the occasional slightly higher co-pay.

I understand I am financially responsible to Alvin C. Matthews DDS, PC for charges not covered by this assignment. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collections fees. Please remember that benefits coverage is a legal agreement between you and your insurance company. Our office is not involved in that agreement and your dental treatment is determined by your oral health, not your insurance company's reimbursement schedule. For the most accurate information regarding your benefits, please contact your insurance provider.

________________________________ ________________

Authorized Signature of Covered Person/ Parent Date

YOU HAVE RECEIVED :

PRIVACY/ HIPPA NOTICE ☐ Received ☐ Declined __________ __________

Initials Date

LUMINEERS® BY CERINATE® SMILE EVALUATION

A Simple Quiz to Help You Obtain the Smile You've Always Wanted

NO PAIN—YOU DON'T EVEN NEED AN ASPIRIN.

THE MOST SIGNIFICANT COSMETIC ADVANCEMENT EVER!

Hold a mirror 12"–14" from your face. Smile to show your teeth. Take the time to observe your teeth carefully, then answer the following questions:

1 Do you like the appearance of your teeth and your smile? ❑ Yes ❑ No
If not, explain ______________________________

2 Are your teeth all in alignment (straight)? ❑ Yes ❑ No
If not, explain ______________________________

3 Do you have spaces that you don't like? ❑ Yes ❑ No
If yes, explain ______________________________

4 Do you like the color of your teeth? ❑ Yes ❑ No
If not, explain ______________________________

5 Do you like the shape of your teeth? ❑ Yes ❑ No
If not, explain ______________________________

6 Are your teeth...
Chipped? ❑ Yes ❑ No Protruding ❑ Yes ❑ No Hidden ❑ Yes ❑ No
If yes, explain ______________________________

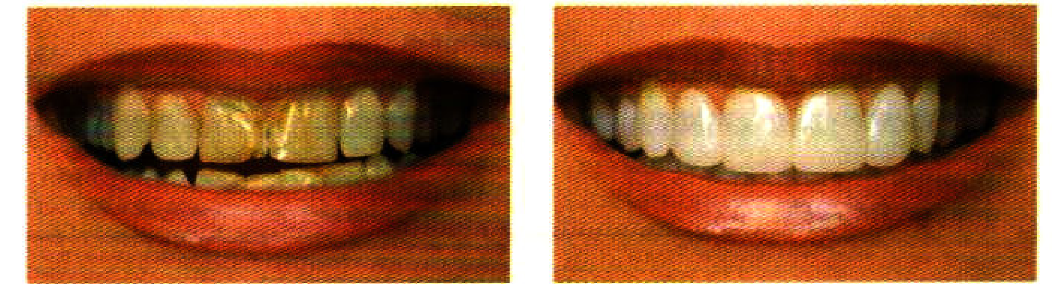
7 Are your teeth wearing on the biting surfaces? ❑ Yes ❑ No
If yes, explain ______________________________

8 Are there old fillings or dental work you don't like looking at? ❑ Yes ❑ No
If yes, explain ______________________________

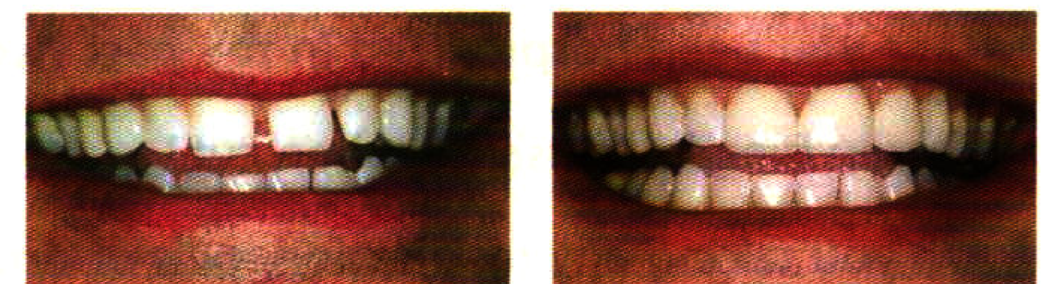
9 What would you like to change the most in the appearance of your teeth?
____

10 How would you like your teeth to look?
____

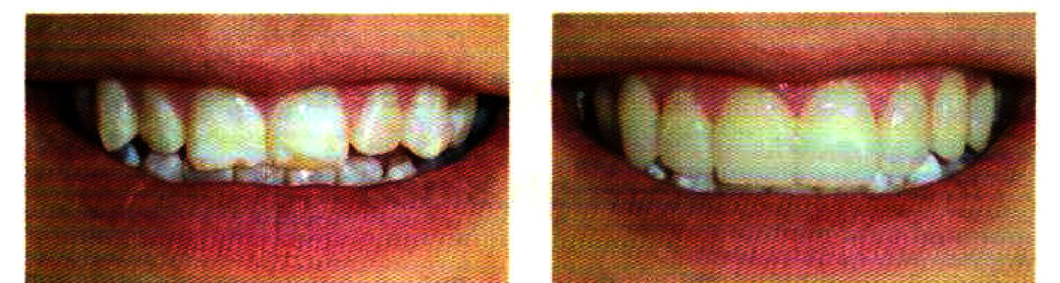
If you are not happy with the appearance of your teeth, ask your dentist how LUMINEERS can improve your smile.



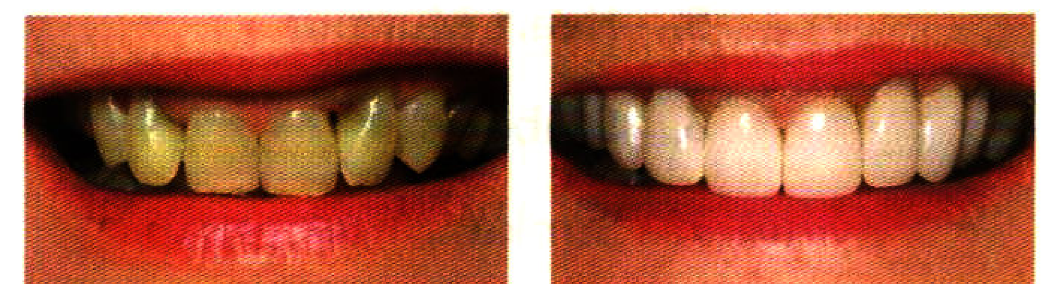
STAINED AND CHIPPED



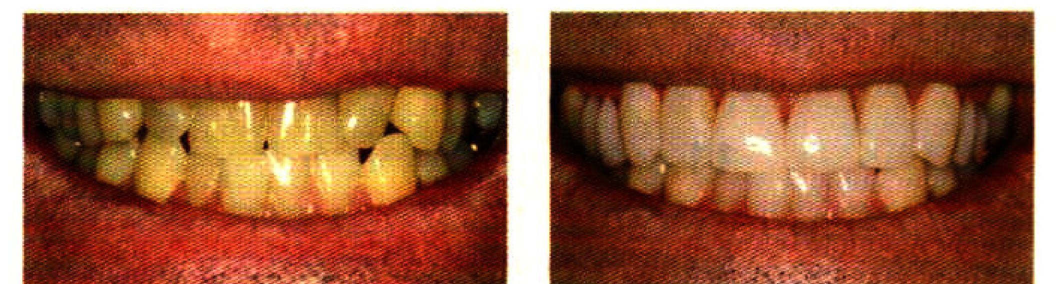
SPACES



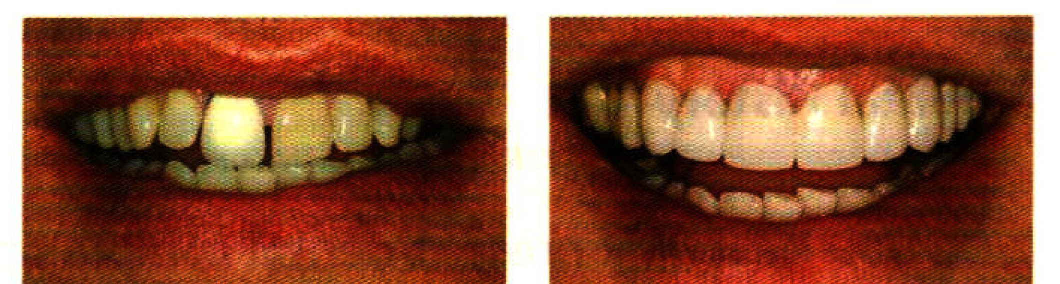
CALCIFICATION STAINS



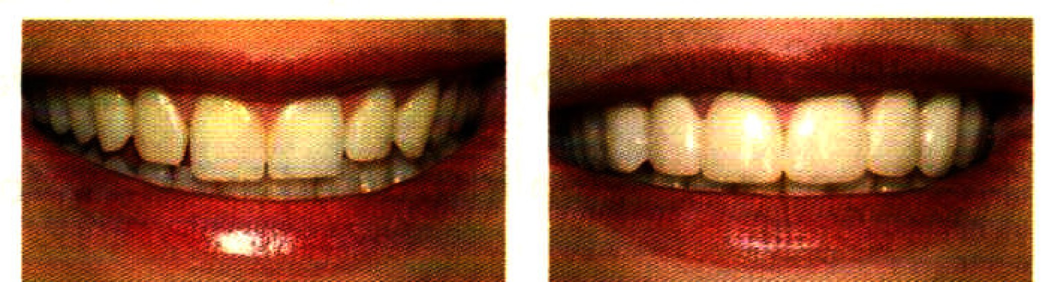
FANGED TEETH



STAINED AND CROOKED TEETH



PORCELAIN CROWNS



BEAUTIFUL SMILE

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BY CERINATE®
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Health History

Mr. Mrs. Miss Ms. ________________ Birthdate ________ Age ______ Soc. Sec. No. ________

Home address ________________ City ________ State ________ Zip ________ Phone ________

Dental Insurance ________________ Group or Plan No. ________________ Referred By ________

Person financially responsible ________________ Relationship to you ________________ Soc. Sec. No. ________

Spouse/Partner name ________________ Birthdate ________ Employer ________________ Soc. Sec. No. ________

Occupation ________________ Employer ________________ Phone ________

Person to contact in case of emergency ________________ Phone ________

Medical History

Physician ________________ Address ________________ Phone ________

Are you in good health? ______ If no, explain ________________

Do you have an existing illness? ______ If yes, explain ________________

Have you been hospitalized in the past two years? ______ If yes, explain ________________

Do you bleed excessively when cut? ______ Do you smoke? ______ If yes, how much? ________

Are you taking any medication, pills or drugs? ______ If yes, please list: ________________

Do you now have, or have you had any of the following? (If yes, describe under remarks.)

	YES	NO		YES	NO
1. Heart Disease	❑	❑	14. Liver Disease	❑	❑
2. High Blood Pressure	❑	❑	15. Kidney Disease	❑	❑
3. Blood Disease	❑	❑	16. Hepatitis	❑	❑
4. Rheumatic Fever	❑	❑	17. Asthma	❑	❑
5. Heart Murmur	❑	❑	18. Tuberculosis	❑	❑
6. Diabetes	❑	❑	19. AIDS or HIV positive	❑	❑
7. Stroke	❑	❑	20. Allergy to: (a) Penicillin	❑	❑
8. Epilepsy	❑	❑	(b) Other Antibiotics	❑	❑
9. Arthritis	❑	❑	(c) Local Anesthetics	❑	❑
10. Tumor History	❑	❑	(d) Other	❑	❑
11. VD	❑	❑	21. Are you pregnant?	❑	❑
12. Nervous Disorders	❑	❑	22. Have you ever used Fen-Phen?	❑	❑
13. Radiation Treatment	❑	❑			

Dental History

Do you have any present dental complaints? ❑ Yes ❑ No What? ________________

When was your last full-mouth X-ray taken? ________________ Where? ________

When was your last cleaning? ________________ Where? ________

Have you ever been instructed in the prevention of decay? ________________

Have you ever been instructed in caring for your gums? ________________

Remarks

____

____

I consent to whatever dental procedures and anesthetics are necessary for the treatment of the above named patient.

I also agree to assume full financial responsibility for all treatment rendered.

Signature ________________ Date ________