



Address: 2680 S Val Vista Rd #125 Gilbert, AZ 85295 Phone: 480.553.9909

Medical Alert For Office Use

Thank you for visiting Copper Canyon Dental. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information

Name _____
LAST FIRST MIDDLE INITIAL PREFERRED NAME

Address _____
NUMBER STREET

CITY STATE ZIP

Employer _____ Email Address _____

Birth Date _____ Height _____ Weight _____ Sex M / F

Phone () _____
HOME MOBILE

() _____
WORK

Social Security # _____

Emergency Contact _____ PHONE () _____
NAME PHONE

Insurance

Primary Dental Carrier

Suscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # () _____ Group # _____

Relation to Patient _____

Secondary Dental Carrier (United Concordia, Cigna PPO, MetLife, United Concordia, Delta Premiere, Delta Dental of AZ, Only)

Suscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # () _____ Group # _____

Relation to Patient _____

Insurance Authorization Statement (Sign & Date)

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature _____ Date _____

If Patient is Under 18

Responsible Party _____ Relation to Patient _____

Address _____
NUMBER STREET

CITY STATE ZIP

Phone () _____

Financial Agreement

For my convenience, this office may release my information to my insurance company, and receive payment directly from them. I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time. In the event my account is sent to collections, I agree to pay all related fees and court costs. Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible. I agree to pay a finance charge of 1.5% per month on any balance 90 days past due. If an appointment is broken without a 24 hour notice, Copper Canyon Dental reserves the right to charge a broken appointment fee of \$50.00, which I will be responsible for paying. Treatment plans may change, and I will be responsible for work actually done.

Signature _____ Date _____

Notice of Privacy Policies

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities and healthcare operations. I also understand that I have the right to revoke that permission. I also agree to allow photographs to be used for education, training, and advertising purposes.

Signature _____ Date _____

Medical History

Name of Medical Doctor _____ City / State _____

List all the medications or drugs you are now taking:

None _____

List all the medications or drugs you allergic to:

NKA _____

Circle any medical conditions you may have including: asthma, bleeding problems, cancer, diabetes, heart murmur, heart trouble, high blood pressure, joint replacement, kidney disease, liver disease, pregnancy, psychiatric treatment, sinus trouble, stroke, ulcers, or history of rheumatic fever, fen-phen, bisphosphonates, or illicit drug use.

PLEASE LIST ANY OTHER MEDICAL CONDITIONS _____

Tobacco Use? None _____
IF YES, PLEASE EXPLAIN

Alcohol Use? None _____
IF MORE THAN A FEW DRINKS PER WEEK, PLEASE EXPLAIN

Any unusual reactions to dental injections? None _____ Severe Dental Anxiety? None Yes

Reason for today's visit? _____

If you were to need treatment, what is more important? Cost Quality, long-lasting materials Both

Are you more interested in? Preventative care to avoid pain Handling problems as they arise (i.e. pain or broken tooth)

Please rank from most important (one) to least important (five): Avoiding Pain

Keeping your teeth as long as possible.

Making sure your teeth function well for a lifetime.

How your teeth look.

The cost of keeping your teeth and mouth healthy.

How did you hear about us? _____

Is there anything you would like to change about your smile? _____

Which whitening products have you used? Crest White-strips Custom trays w/ gel In-office laser whitening (i.e. zoom)

Why did you leave your last dentist? _____ What did you like MOST about them? _____

Treatment Authorization

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary and advisable including the use of local anesthesia and other medications as indicated. I certify to the above statements regarding my medical condition.

Signature _____ Date _____