



Sienna Springs PLLC

D E N T A L

SCOTT A. CURRY, DDS

GENERAL DENTISTRY

COSMETIC DENTISTRY

Preventive Care
Crowns, Bridges
Dentures
Tooth Colored Fillings
Root Canals
In house Oral Surgery

Whitening / Bleaching
Porcelain Veneers
Cosmetic Bonding & Reconstruction

(480) 279-5233

1355 S. Higley Road • Suite 120 • Higley, Arizona 85236

Please complete the following Patient Registration and Confidential Health History

1
Step

*If the appointment is for you,
Please Start Here*

Today's Date

Name Sex

Street Address

City State Zip Code

Home Phone # Work Phone # Cell or Pager # (if applicable)

Driver License # Birth Date SS#

Single Married Divorced Widowed E-Mail Address

1
Step

*If the appointment is for your child,
Please Start Here*

Today's Date

Child's Name Sex

Street Address

City State Zip Code

Home Phone # Birth Date Age

School Grade

3
Step

Person Financially Responsible for Account

Name

Address City State Zip

Home Phone # Work Phone # Ext #

SS# Drivers License #

Employer

Work Address City State Zip

Spouse's Name

Employer Work Phone # Ext #

Work Address City State Zip

Insurance Information

Group #

Dental Insurance Company Phone #

Street Address

City State Zip Code

Employer Phone #

Insured Employee Name Birth Date

Date Employed Insured Employee SS#

4
Step

Getting to Know You

How did you hear about Sienna Springs Dental?

Your Hobbies and Interests

Is a member of your family a patient in our office?

Yes

No

Their Name

Address City State Zip

Please Note-

***We require 48 hours notice if a patient cannot keep a scheduled office appointment. This allows us to accommodate other patients. All patients who cancel appointments with fewer than 48 hours will be subject to a \$50 cancellation fee.**

5
Step

Emergency Contact Information

Name of an individual you would like us to contact in an emergency?

Address City State Zip

Home Phone #

Work Phone #

Ext #

Closest Relative *not* living with you?

Address City State Zip

Home Phone #

Work Phone #

Ext #

6
Step

Office Policies and Federal Truth-in-Lending Statement; Please Read:

As a condition of your treatment by this office, financial arrangements must be made in advance. Patient co-payments (*the amount not covered by insurance*) are due and payable at the time of service.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A service charge of a 1.5% per month (*18% per annum*) on the unpaid balance will be assessed on all accounts exceeding sixty days from the date of service. Fee estimates for dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request for my minor child or ward by the dentist, I agree to pay, the reasonable value of said services to said dentist or his assignee at the time said services are rendered, or within thirty (30) days of billing if credit shall be extended, I further agree that the reasonable values of said services shall be as billed unless objected to by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if suit is instituted hereunder to collect monies owed by me, including interest charges, processing fees or commissions (*up to 50% of principle*) that may be assessed by any collection agency retained to pursue this matter.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters relating to this form.

I authorize assignment or payment of all dental and/or surgical benefits to which I or other family members are entitled, including private dental insurance and other group health plan benefits otherwise payable to the undersigned, to Dr. Scott A. Curry, D.D.S.

I certify that I have answered all questions on the form accurately, and I hereby agree to abide by the conditions outlined therein.

7
Step

Please Sign Below

Signature of Patient, Parent or Guardian

Date

Relationship to Patient



SCOTT A. CURRY, DDS
Cosmetic & Family Dentistry

Patient Name

(480) 279-5233

1355 S. Higley Road • Suite 120 • Higley, Arizona 85236

1 Medical History Form; please read and answer the following questions:

- Yes No
1. Are you having pain or discomfort at this time?
 2. Do you have or have you ever had bleeding or sensitive gums?
 3. Do you feel nervous about having dental treatment?
 4. Have you been hospitalized during the past two years?
 5. Have you been under the care of a medical doctor during the past two years?
Physician's Name _____ Type of Practice _____
Address _____ Phone _____
 6. Have you taken any medication or drugs during the past two years?
 7. Are you now taking any medication, drugs or pills?
If yes, please list _____
 7. Are you currently taking any dietary supplements (including herbs)? If yes, please list _____
 7. Are you allergic or have you reacted adversely to any of the following?

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Barbiturates
<input type="checkbox"/> Codeine	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Latex	<input type="checkbox"/> Do you have any other allergies? If yes, please list _____
<input type="checkbox"/> Nitrous Oxide	<input type="checkbox"/> Other Antibiotics	<input type="checkbox"/> Ibuprofen	
<input type="checkbox"/> Tetracycline	<input type="checkbox"/> Local Anesthetic	<input type="checkbox"/> Acetaminophen	
 8. Check any of the following which you *have* at the present *or have had* in the past:

<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Emphysema	<input type="checkbox"/> A.I.D.S. or H.I.V.
<input type="checkbox"/> Heart Disease or Attack	<input type="checkbox"/> Cough	<input type="checkbox"/> Hepatitis A (<i>infectious</i>)
<input type="checkbox"/> Angina Pectoris	<input type="checkbox"/> Tuberculosis (<i>TB</i>)	<input type="checkbox"/> Hepatitis B (<i>serum</i>)
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis C
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Yellow Jaundice
<input type="checkbox"/> Congenital Heart Lesions	<input type="checkbox"/> Allergies or Hives	<input type="checkbox"/> Blood Transfusion
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hemophilia
<input type="checkbox"/> Heart Pacemaker	<input type="checkbox"/> Thyroid Disorders	<input type="checkbox"/> Fever Blisters
<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> X-ray or COBALT Treatment	<input type="checkbox"/> Epilepsy or Seizures
<input type="checkbox"/> Artificial Joints (<i>Hip, Knee</i>)	<input type="checkbox"/> Chemotherapy (<i>Cancer, Leukemia</i>)	<input type="checkbox"/> Fainting or Dizzy Spells
<input type="checkbox"/> Anemia	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Stroke	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Psychiatric Treatment
<input type="checkbox"/> Kidney Trouble	<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Bruise Easily
<input type="checkbox"/> Cosmetic Surgery	<input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Cold Sores	Other _____
 9. When you walk up stairs or take a walk do you ever have to stop because of pain in the chest, shortness of breath, or because you are very tired?
 10. Do your ankles swell during the day?
 11. Are you on a special diet? if *yes*, please explain _____
 12. Have you ever taken Phen-Fen or similar appetite suppressants? If *yes*, have you seen your physician or cardiologist for a cardiac evaluation? _____
 13. Do you have any disease, condition or problem not listed? _____
 14. Have you visited a dentist in the past year? Date of last dental visit _____
 15. **FOR WOMEN ONLY:** *Are you pregnant?* If *yes*, what month? _____
 16. **FOR WOMEN ONLY:** Are you taking birth control pills?

Signature of Patient, Parent or Guardian

Date

Relationship to Patient

I hereby certify that the answers to the above questions are accurate to the best of my knowledge.

2 *Step* **Health Questionnaire and Acknowledgement with Consent to Proceed; Please Read:**

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Dr. Scott A. Curry, D.D.S., and/or such associates or assistants as he may designate, to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects which may include but are not limited to, bruising, hematoma, cardiac stimulation, temporary or rarely, permanent numbness, and muscle soreness.

I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or possibly quite painful both during and after completion of treatment. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me as necessary and I have been given the opportunity to ask questions.

3 *Step* **Please Sign Below**

Signature of Patient, Parent or Guardian

Date

Relationship to Patient

Signature of Witness

Date

4 *Step* **Review of Medical History**

I have reviewed the foregoing Medical History (other side) and find it to be unchanged and accurate except as noted:

Signature of Patient, Parent or Guardian

Date

Updated Information

Signature of Dentist

Signature of Patient, Parent or Guardian

Date

Updated Information

Signature of Dentist

Signature of Patient, Parent or Guardian

Date

Updated Information

Signature of Dentist