

# West Valley Endodontics and Oral Surgery

## New patients

Welcome to our practice. Our primary purpose is to serve you and your family, to provide for your dental health needs in a considerate and caring fashion. For your protection, this office has the most modern equipment, the latest techniques, above all, we follow OSHA guidelines in advanced sterilization technology for both staff and patient protection.

## Consent for Services

As a Condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, and any dental services performed without previous financial arrangements, must be paid for in full at time services are preformed. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

(Initials)\_\_\_\_\_

## Medical and Dental Authorization

I have read the information on the health questionnaire and it is accurate to the best of my knowledge. I understand that the dentist to help determine appropriate and helpful dental treatment will use this information provided. If there are any changes in my medical status, I will inform the dentist.

(Initials)\_\_\_\_\_

## Insurance Authorization

If you have dental insurance, we will gladly process your forms. **However, we request that you pay your estimated portion when services are rendered. Please remember that our contract for payment is with you and not your insurance carrier.** We are happy to bill your insurance as a courtesy to you, when you have provided us with your complete insurance information. We allow 45 days from the date of service for payment from an insurance company. After this period, we ask you to become responsible for payment of all unpaid fees.

(Initials)\_\_\_\_\_

## Payment Options

**Payment is due at the time of treatment.** We accept cash, check, and all major credit cards. We also have two no interest payment plans, Care Credit and All Care, that allows you to start treatment today and spread payments over time. Applying for Care Credit and All Care only takes a few minutes and there is no fee to apply.

(Initials)\_\_\_\_\_

**I HAVE READ THE ABOVE OFFICE POLICIES AND CONDITIONS OF TREATMENT AND AGREE TO THEIR CONTENT.**

\_\_\_\_\_  
Signature of patient, parent or guardian

\_\_\_\_\_  
Date

## **PATIENT INFORMATION**

Name \_\_\_\_\_ Birth date \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex \_\_\_\_ M \_\_\_\_ F \_\_\_\_ Married \_\_\_\_ Widowed \_\_\_\_ Minor \_\_\_\_ Single \_\_\_\_ Divorced

E-mail \_\_\_\_\_ Do we have your permission to email you our news letter **YES / NO**

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Pharmacy Info \_\_\_\_\_ Pharmacy Phone \_\_\_\_\_

Pharmacy Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

I give \_\_\_\_\_ permission for West Valley Endodontics and Oral Surgery to communicate with them regarding my Dental treatment or any question regarding billing, and/or my appointments

## **Responsible Party**

Name of Person  
Responsible for this Account \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Driver's License # \_\_\_\_\_ Birthday \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

## **Insurance Information**

Name of Insured \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Birthday \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance ID# \_\_\_\_\_ Insurance Phone \_\_\_\_\_

## **Additional Insurance Information**

Name of Insured \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Birthday \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance ID# \_\_\_\_\_ Insurance Phone \_\_\_\_\_

***Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please circle your responses.***

## Health History Form

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Gender: Male / Female      Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI \_\_\_\_\_

Please describe your current health:      Excellent      Good      Fair      Poor

Please describe the symptoms you are currently having today: \_\_\_\_\_

Have there been any changes in your general health in the past year?      Yes      No

If yes, please describe: \_\_\_\_\_

Are you now under a physician's care for a particular problem at this time?      Yes      No

If yes, why? \_\_\_\_\_ Date of last physical exam \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you ever been hospitalized or had a serious illness?      Yes      No

If yes, why? \_\_\_\_\_

Have you ever had surgery?      Yes      No

If yes, when and what for? Date of surgery: \_\_\_\_\_ Reason for surgery: \_\_\_\_\_

Date of surgery: \_\_\_\_\_ Reason for surgery: \_\_\_\_\_

---

### PATIENT MEDICAL HISTORY

**Do you have or have you ever had:**

Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)?	Yes	No	Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?	Yes	No
--	-----	----	---	-----	----

Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)?	Yes	No	Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	Yes	No
---	-----	----	--	-----	----

Kidney disease or kidney failure, requiring dialysis?	Yes	No	Liver disease (jaundice, hepatitis A, B, or C)?	Yes	No
---	-----	----	---	-----	----

Thyroid disease?	Yes	No	Arthritis?	Yes	No
------------------	-----	----	------------	-----	----

Stomach ulcers or colitis?	Yes	No	Significant weight loss or gain?	Yes	No
----------------------------	-----	----	----------------------------------	-----	----

Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes	No	Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No
--	-----	----	---	-----	----

Frequent or recurring mouth sores?	Yes	No	Sinus or nasal problems?	Yes	No
------------------------------------	-----	----	--------------------------	-----	----

Glaucoma?	Yes	No	Sleep apnea?	Yes	No
-----------	-----	----	--------------	-----	----

Diabetes?	Yes	No	Osteoporosis or osteopenia?	Yes	No
-----------	-----	----	-----------------------------	-----	----

Any cancer, radiation, or chemotherapy?      Yes      No

Describe: \_\_\_\_\_ Date of your last treatment? \_\_\_\_\_

Do you have any other disease, condition or problem not listed above that you think the doctor should know about?

If yes, please explain: \_\_\_\_\_

---

**FAMILY MEDICAL HISTORY****Do you have a family history of any of the following? If yes, indicate the relationship.**

Diabetes? Yes No Relationship \_\_\_\_\_ Cancer? Yes No Relationship \_\_\_\_\_  
Heart disease? Yes No Relationship \_\_\_\_\_ Bleeding problems? Yes No Relationship \_\_\_\_\_  
Tumors? Yes No Relationship \_\_\_\_\_ Lung disease? Yes No Relationship \_\_\_\_\_

---

**FEMALE PATIENTS**

Are you pregnant, or is there any chance you might be pregnant? Yes No

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

---

**MEDICATIONS****Are you using any of the following:**

Antibiotics?	Yes	No	Prescription pain medication?	Yes	No
Anticoagulants (blood thinners)?	Yes	No	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	Yes	No
Heart medications?	Yes	No	Insulin or oral anti-diabetic drugs?	Yes	No
Steroids (cortisone, prednisone, etc.)?	Yes	No	Blood pressure medications?	Yes	No
Antianxiety agents, antidepressants or other psychiatric medications?	Yes	No	Bisphosphonates, antiangiogenic and/or antiresorptive medications for osteoporosis, multiple myeloma or other cancers? If yes, list drugs used and time of use.	Yes	No

\_\_\_\_\_

\_\_\_\_\_

Please list any specific medications indicated above and/or any other medications not listed above that you are currently taking including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals:

Medication	Dosage	Medication	Dosage

---

**ALLERGIES****Are you allergic to or have you had an adverse reaction to:**

Latex?	Yes	No	Codeine or other pain killers?	Yes	No
Food products?	Yes	No	Aspirin, Motrin, Aleve, or ibuprofen?	Yes	No
Sedatives, barbiturates?	Yes	No	Penicillin or other antibiotics?	Yes	No

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes No If yes, which anesthetic? \_\_\_\_\_ Relationship? \_\_\_\_\_

Other drug allergies not listed above: \_\_\_\_\_

---

**SOCIAL HISTORY**

Have you ever smoked or chewed tobacco? Yes No

If yes, for how long? \_\_\_\_\_

**Have you ever sought professional care or been hospitalized for:**

Substance abuse?	Yes	No
Emotional disorders?	Yes	No
Alcoholism?	Yes	No

**Do you use:**

Alcohol?	Yes	No	How often?	_____
Marijuana?	Yes	No	How often?	_____
Recreational drugs?	Yes	No	How often?	_____

---

---

**DENTAL HISTORY**

Have you had any adverse effects from dental treatment? Yes No If Yes, please explain? \_\_\_\_\_

Do you wish to talk to the doctor privately about anything? Yes No

---

**I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible.**

\_\_\_\_\_  
Signature of patient, parent, guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient, parent, guardian/Relationship

\_\_\_\_\_  
Doctor's Signature

**HEALTH HISTORY UPDATE**

Date

Comments

Doctor's Signature

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Authorization and Release**

To the best of my knowledge, the information provided in this packet is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have change in health. I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ assign directly to **West Valley Endodontics and Oral Surgery** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named facility may use my health care information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Date

## **NOTICE OF PRIVACY PRACTICES**

**West Valley Endodontics and Oral Surgery  
14122 McDowell Road Suite 201  
Goodyear, Arizona 85395**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Our commitment here at West Valley Endodontics and Oral Surgery is to serve our patients with professionalism and caring, being sure at all times to PROTECT the privacy and security of all Protected Health Information.

During the course of serving your interests, it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where information may be shared:

- For payment purposes, we may use the services of a billing service.
- During dental care, we may need to consult with your physician or previous dentist.
- For payment purposes, we need to supply information requested from your dental insurances company.

We here at West Valley Endodontics and Oral Surgery are committed to obeying all Federal, State, and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. The individual, as provided by law, may revoke this written authorization at any time.

If you have any questions or comments regarding your Protected Health Information, feel free to contact our Compliance Officer: (623)444-4521.

I have read and understand the above Notice of Privacy Practices.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Patient or Legal Guardian)



## **Oral Surgery Financial & Scheduling Policies**

### **Deposit amount**

Our office requires a 25% deposit of your dental treatment cost with a \$100 non-refundable deposit to reserve your appointment date, and it's due at the time of reserving your appointment. In which the deposit will be applied to your dental procedure.

### **Appointment reservation**

You are welcome to make your reservation for surgery on the day of your consultation. If you later realize that work or other scheduling conflicts exist, your deposit will be fully credited toward a more convenient surgery date so long as 3 business day notice is given.

### **Rescheduling**

In order to receive full credit for your deposit, please notify our office at least 3 business days prior to your scheduled procedure date. We understand that personal situations can arise unexpectedly, and you may reschedule your surgery as often as necessary without penalty provided we receive 3 business days advance notice.

### **Final Payment**

Final payments must be received at the time of the surgical appointment.

The following policies have been designed to maintain an efficient surgery schedule and ensure the fair distribution of the doctor's surgery time for all patients. We hope the policies do not cause significant inconveniences and truly appreciate your cooperation. Thank you for placing your trust in West Valley Endodontics and Oral Surgery.

**I certify that I have read this form, fully understand, and comply with the financial terms related to my surgical procedure.**

---

Signature of Patient/Guardian

---

Date