DIAZO
FAMILY DENTAL & BRACES

Date_____

Patient Information

Patient's Name_____ Birth Date_____ Sex: (M) (F) SS:_____-____-_____

If minor, parents names_____ Home Phone_____ Cell Phone_____

Home Address _____Unit _____City _____State_____ Zip_____

Employer _____Position _____Work Phone (___) _____

Email : _____

How did you hear of us? TV_____ QueCalor_____ TV y Mas____ The Internet_____ Family referral_____

Insurance Information

Subscriber's Name _____Date of Birth_____/____/_____

Dental Insurance Co. _____ SSN_____ Group number_____

Covered by spouse's insurance? Yes No

Spouse's dental insurance co._____ Group number_____

Spouse's birthday_____SSN_____

Medical Health History

Primary reason for this dental appointment: Examination Emergency Consultation

Medical History

Are you under a physician's care now? Yes No Why? _____ Phone_____

Do you have any disease, condition, or problem not listed below?

_____

Have you in the past taken any medications for your bones or Osteoporosis?

_____

Are you ALLERGIC to any medication or substance listed below?

- o Latex materials
- o Penicillin or other antibiotics
- o Local anesthetic(“Novocain”)
- o Codeine or other narcotics
- o Barbiturates, sedatives, or sleeping pills
- o Aspirin
- o Other_____

Are you taking any of the following?

- o Aspirin
- o Anticoagulants (blood thinners)
- o Antibiotics or sulfa drugs
- o High Blood pressure medicine
- o Antidepressants or tranquilizers
- o Insulin, or other diabetes drug
- o Cortisone or other steroids
- o Osteoporosis (bone density) medicine
- o Bone medication_____
- o Other:_____

Women:

- o Pregnant Expected delivery date:_____
- o Taking hormones or contraceptives

Do you now have or have you ever had any of the following? Please Check all that apply.
*If yes to any of the starred conditions, please call prior to your next appointment if premedication is required.

- o Cancer or tumor
- o Heart ailment or angina
- o Heart murmur, mitralvalve prolapse, heart defect
- o Rheumatic fever or rheumatic heart disease
- o Artificial joint or valve
- o High or low blood pressure
- o Pacemaker
- o Tuberculosis or other lung problems
- o Kidney disease
- o Alcoholism
- o Blood transfusion
- o Diabetes
- o Neurologic condition
- o Epilepsy, seizures, or fainting spells
- o Emotional condition
- o Arthritis
- o Herpes or cold sores
- o AIDS or HIV positive
- o Migraine headaches or frequent headaches
- o Anemia or blood disorders
- o Abnormal bleeding after extractions, surgery, or trauma
- o Hay fever or sinus trouble
- o Allergies or hives
- o Asthma

Please add anything else you would like us to know about:

_____

_____

Please list all Medications that you are currently taking

Signature: _____ Date: _____

Appointments and Cancellations

6544 W THOMAS RD Suite 8
PHOENIX, AZ 85033
P: (623) 845-7400 F: (623)245-4159

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment, please give us at least a 24 hours' notice. This courtesy makes it possible to give your reserved room to another patient who would like it.

Missed Appointment Policy

Due to high number of patients requiring dental care, waiting times for appointments can be long. Because of this we enforce a missed appointment policy to ensure that all of our patients receive care in a timely manner. Missed appointments and appointment cancelled without a 48 hour notice are subject to a $25 cancellation fee.

There is a $25 charge for not showing up for your scheduled appointment. Repeated cancellations or missed appointment will result in loss of future appointment privileges.

_____ _____

Signature Date

Diazo Family Dental & Braces
Dental Financial Policy and Agreement

Thank you for choosing us for your dental needs. We are committed to providing you with excellent care.
Our convenient financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees and patients' financial capabilities.

Payment

Payment in full is due at the time of service unless prior financial arrangements are made. We offer several payment options:

- Cash, Checks, Visa, MasterCard, Discover, and American Express
- Pre-payment Discounts
- Monthly payment plans in accordance with the office credit guidelines
- Care Credit payment options (6,12,and 18 no interest plans or 24-60 extended 14.9% Interest Plans)

Insurance

Our office is committed to helping patients maximize their benefits. Because Insurance policies vary greatly, we can estimate your coverage in good faith, but cannot guarantee it. As a service to our patients, we will be happy to manage all claim submission and follow up on your behalf. It is the patients' responsibility to provide us with current insurance information. If any payment from an insurance company becomes 30 days past due, you will be immediately billed for the entire balance.

We will file pre-treatment estimates, AT YOUR REQUEST ONLY. Please be aware that some insurance companies may not honor pre-treatment estimates or may alter it. In all cases it may delay important dental care. Not ALL services are covered by insurance. In the event that the insurance plan determines a service to be "not covered" you will be responsible for the complete charge. Our staff can never guarantee your eligibility and coverage.

If you have any questions our knowledgeable and courteous staff is always available to answer them.

Collection Fees

Fees incurred to collect payment will be billed to and payable by the patients account holder.
Past due accounts may be turned over to a collection agency.

Financial Consent

The patient (account holder) agrees to be fully responsible for total payment of treatment preformed in this office.
I understand and agree to this financial Policy and Agreement.

_____ _____

Signature Date