

# Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.



## Patient Information

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
*Last Name First Name Initial*

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced

Patient Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Email \_\_\_\_\_

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

Notify in case of emergency \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Email \_\_\_\_\_



## Primary Insurance

Person Responsible for Account \_\_\_\_\_  
*Last Name First Name Initial*

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_ Home Phone \_\_\_\_\_

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

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Email \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Email \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Name of other dependents under this plan \_\_\_\_\_

## Additional Insurance



Is patient covered by additional insurance?  Yes  No

Subscriber Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Subscriber Employed by \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Email \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Email \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Name of other dependents under this plan \_\_\_\_\_

Please complete both sides.



# Dental History

What would you like us to do today? \_\_\_\_\_ Are you in dental discomfort today? \_\_\_\_\_

Former Dentist \_\_\_\_\_ Address \_\_\_\_\_

Dentist's Email \_\_\_\_\_ Phone \_\_\_\_\_

Date of last dental care \_\_\_\_\_ Date of last x-rays \_\_\_\_\_

Check (✓) yes or no if you have had problems with any of the following:

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Bad breath              | <input type="checkbox"/> Y <input type="checkbox"/> N Food collection between teeth  | <input type="checkbox"/> Y <input type="checkbox"/> N Periodontal treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to sweets     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding gums           | <input type="checkbox"/> Y <input type="checkbox"/> N Grinding or clenching teeth    | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to cold   | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity when biting   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Clicking or popping jaw | <input type="checkbox"/> Y <input type="checkbox"/> N Loose teeth or broken fillings | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to hot    | <input type="checkbox"/> Y <input type="checkbox"/> N Sores or growths in mouth |

How often do you brush? \_\_\_\_\_ Floss? \_\_\_\_\_

How do you feel about the appearance of your teeth? \_\_\_\_\_

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?  Y  N

Other information about your dental health or previous treatment \_\_\_\_\_



# Medical History

Physician's name \_\_\_\_\_ Phone \_\_\_\_\_

Date of last visit \_\_\_\_\_ Have you had any serious illnesses or operations?  Y  N

If yes, describe \_\_\_\_\_

Are you currently under physician care?  Y  N If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  Y  N If yes, give approximate dates \_\_\_\_\_

Have you ever taken Fen-Phen/Redux?  Y  N

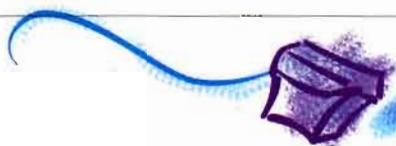
Women: Are you pregnant?  Y  N Nursing?  Y  N Taking birth control pills?  Y  N

Check (✓) yes or no whether you have had any of the following:

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Positive       | <input type="checkbox"/> Y <input type="checkbox"/> N Cough, persistent            | <input type="checkbox"/> Y <input type="checkbox"/> N Jaw pain   | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles                   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anaphylaxis             | <input type="checkbox"/> Y <input type="checkbox"/> N Cough up blood               | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney disease or malfunction                      | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath        |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia                  | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes                     | <input type="checkbox"/> Y <input type="checkbox"/> N Liver disease                                      | <input type="checkbox"/> Y <input type="checkbox"/> N Skin rash                  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis, Rheumatism   | <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy                     | <input type="checkbox"/> Y <input type="checkbox"/> N Material allergies (latex, wool, metal, chemicals) | <input type="checkbox"/> Y <input type="checkbox"/> N Spina Bifida               |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial heart valves | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting                     | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral valve prolapse                              | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke                     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial joints       | <input type="checkbox"/> Y <input type="checkbox"/> N Food allergies               | <input type="checkbox"/> Y <input type="checkbox"/> N Nervous problems                                   | <input type="checkbox"/> Y <input type="checkbox"/> N Surgical implant           |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma                  | <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma                     | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker/Heart surgery                            | <input type="checkbox"/> Y <input type="checkbox"/> N Swelling of feet or ankles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Atopic (allergy prone)  | <input type="checkbox"/> Y <input type="checkbox"/> N Headaches                    | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric care                                   | <input type="checkbox"/> Y <input type="checkbox"/> N Tobacco habit              |
| <input type="checkbox"/> Y <input type="checkbox"/> N Back problems           | <input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur                 | <input type="checkbox"/> Y <input type="checkbox"/> N Rapid weight gain or loss                          | <input type="checkbox"/> Y <input type="checkbox"/> N Tonsillitis                |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood disease           | <input type="checkbox"/> Y <input type="checkbox"/> N Heart problems               | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation treatment                                | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis               |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer                  | Describe _____   | <input type="checkbox"/> Y <input type="checkbox"/> N Respiratory disease                                | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcer/Colitis              |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemical dependency     | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/Abnormal bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet fever                            | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal disease           |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy            | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes                       |  |  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Circulatory problems    | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis                    |  |  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cortisone treatments    | <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure          |  |  |

Is patient currently taking any medications? If yes, list all: \_\_\_\_\_

Does patient have drug allergies? If yes, list all: \_\_\_\_\_



# Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

*Payment is due in full at time of treatment, unless prior arrangements have been approved.*

**Township Dental Associates, P.L.L.C.**

1835 East Baseline Road

Gilbert, AZ 85233

(480) 507-5645

[www.townshipdental.com](http://www.townshipdental.com)

**LIMITED DENTAL WARRANTY**

Our practice is proud of the dentistry that we provide for you and your family. Our goal is not to simply correct any dental problems you may have, but to help prevent dental disease in the future to save you time and expense. The long term success of the treatment we provide depends on you: you should take care of your teeth and gums at home and should visit our office for regular professional exams, cleaning and fluoride treatments. Your professionally diagnosed care and recommended treatment varies based on your individual condition.

The primary key to your long-term success is spending a few minutes a day on your home care (brushing, flossing, fluoride and any prescribed products). The second key to success is regular professional examinations, cleanings, x-rays and fluoride treatments (3, 4 or 6 month intervals depending on your condition). Help us to help you maintain your teeth for your lifetime.

Because we are confident of the durability of our treatments, we offer the following limited dental warranties.

**Failure to have your prescribed in-office professional cleanings, exams, and x-rays voids all warranties (minimum of 6 month interval).**

**ONE YEAR WARRANTY**

**Composite (tooth colored) Fillings:** If composite is our recommended treatment, we will replace or repair a failed composite at no charge. If the tooth breaks and requires a crown, we will credit the cost of the filling toward the crown.

**Dental Sealants:** We will repair or replace sealants damaged through normal use at no charge.

**TWO YEAR WARRANTY**

**Dentures and Partial Dentures:** If your denture is damaged under normal use (a tooth chips or breaks, or a flange breaks) we will repair it at no charge. This does not include accidents, such as dropping your denture. Full upper and lower denture patients must be seen once every 12 months to maintain coverage.

**Crowns, Bridges, Inlays, Onlays and Porcelain Veneers:** We will replace or repair these treatments at no charge if they break, are lost, or decay with normal use. This does not include accidents that could also break normal healthy teeth. If a night guard is part of your treatment plan; it must be worn every night, and you must bring it to every dental visit.

Gold and porcelain crowns are similar, except that porcelain can chip. Approximately one out of every 100 porcelain crowns chip and need replacement. If your porcelain crown chips in the first two years, we will replace it at no additional charge. If it chips after the two year period, you will be charged the regular fee for a new crown. If a gold crown was recommended because of clenching, grinding and/or a strong bite, and you choose a porcelain crown/bridge, there is no warranty for porcelain chips or fractures. Please consider this when choosing between a porcelain crown/bridge and a gold crown/bridge.

This warranty does not include anything not mentioned above including but not limited to: root canal therapy and night guards, nor does it cover damage to teeth or dental prosthesis caused by accidents, trauma, neglect or improper use (e.g. biting non-food items, such as ice).

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Patient's Name (Printed)

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Signature of Patient/Parent/Legal Guardian

Date

**CONSENT FORM AND FINANCIAL POLICY**

Thank you for choosing our office for your dental care. We are committed to providing excellent care, great service, and a comfortable atmosphere and consider dental care a life-long need. In order to serve you best, our dentist and/or hygienist will evaluate each tooth in your mouth, screen for oral cancer and review oral hygiene with you.

(Hereafter, "I", "You", or "Your" shall refer to you, the patient or parent. "We" or "Our" shall refer to Township Dental Associates, P.L.L.C.)

As a condition of your treatment in our office, financial arrangements ***must be made in advance***. The practice depends upon reimbursement from you, the patient, for the costs incurred in your dental care and treatment. ***The patient's estimated portion is due at the time of the scheduled procedure.*** It is your responsibility to provide us with your correct insurance information, including the insurance company name, address and telephone number, group name and number, and any other pertinent information. ***We are unable to bill your insurance, or provide you with any estimate, if all of this information is not received at the time of service.***

I realize and agree that insurance coverage is ***estimated*** and not a guarantee of the actual insurance payment; my actual coverage may be more or less than estimated. I realize and agree that my insurance will help pay part of my treatment and that any estimates quoted to me ***are only estimates***. I am ultimately responsible for any portions remaining unpaid by the insurance carrier. I understand and agree that my insurance coverage is an agreement between the patient and the insurance company, and Township Dental Associates does not have access to the specific coverage or exclusions of my plan. I understand and agree that any fee estimate is valid for sixty days from the original date of the patient's examination. Thereafter, fees are subject to change without notice. I understand and agree to pay any unpaid balance ***within thirty days of date of invoice***. I understand and agree that I will be charged an interest rate of 1.5% per month for any unpaid balance on my account. I understand and agree that I will be responsible for any collection, attorney and/or court fees associated with my account.

(Please Initial Here) \_\_\_\_\_

I understand and agree that ***I am required to allow at minimum a twenty-four hour notice*** to Dr. Zamani and/or staff should I need to reschedule or cancel my exclusively reserved appointment time. My dental appointment represents a shared responsibility for both dentist and patient. Office policy is to reschedule patients that are 15 or more minutes late for their appointment. In order to have quality dental care at affordable costs, these appointments must be kept. I understand and agree that if notice is not given, I WILL BE CHARGED a fee up to the amount of the scheduled procedure, with a minimum fee of \$75.00.

(Please Initial Here) \_\_\_\_\_

I give my consent to use local anesthetics, relaxants, analgesia (laughing gas), antibiotics or pain medication if deemed necessary for the completion of any dental treatment. Women taking birth control pills should be aware that antibiotics such as penicillin or erythromycin could possibly counteract the effects of the pill, and you could become pregnant.

I understand and agree that whenever a tooth is extracted, there is a ***possibility*** of infection, bone fracture, temporary paresthesia (numbness) of the lip, gum tongue and/or facial skin. It is possible, ***though rare***, that the paresthesia would be permanent.

I understand and agree that a root canal is an attempt to retain a tooth that would otherwise require extraction. Although root canal treatment has a high degree of success, ***it cannot be guaranteed***. As the tooth is being treated, the root may fracture, instruments may separate, and portions of the canal may be inaccessible to instruments or sterility. It may require a referral for re-treatment, surgery, or ***rarely*** extraction.

I realize that a dental specialist can perform any treatment proposed in this office. ***I will inform the dentist if I desire a specialist to perform the proposed treatment.***

I understand and agree that the preparation of teeth for crowns, bridges, and fillings may, on occasion, traumatize the pulp (nerve). If the pulp is in a weakened condition, this may necessitate a root canal or extraction on that tooth in the future.

Insurance companies will ***usually*** pay at 100% for an adult prophylaxis. This may or may not be the type of cleaning that is appropriate in your case. If you require a deeper cleaning or more extensive treatment, the doctor/hygienist will inform you when you are seen. In the event that you require more than an adult prophylaxis, your insurance coverage may only allow for limited benefits. Please be advised that if you choose to proceed with treatment, you are responsible for all costs incurred, whether your insurance company pays or not. Please also be aware that the patient must continue routine care (recommended examinations with x-rays and cleanings) for our dental guarantee/warranty to be valid.

**DIVORCE DECREES:** This office is NOT a party to your divorce decree. Adult patients are responsible for their account at the time of service. The responsibility for minors rests with the accompanying adult, regardless of which parent carries any dental insurance.

**MINOR PATIENTS:** A parent or adult is REQUIRED to remain in the facility AT ALL TIMES while treatment is being rendered for the minor.

I grant my permission to Township Dental Associates, P.L.L.C. to contact me in writing or by telephone at home, work, or cellular phone to discuss any matters related to my account, appointments, or any other matter relating to my treatment and care.

**I have read the above conditions of treatment and payment, and agree to their content.**

Patient/Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_ **\*VALID FOR 12 MONTHS\*** Document must be updated once a year.

# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Township Dental Associates, P.L.L.C.  
1835 E. Baseline Road  
Gilbert, AZ 85234  
(480) 507-5645

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

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

Relationship to Patient \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

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## OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: