14441 W. McDowell Rd. #B106 • Goodyear, AZ 85395
Office | (623) 536-3264 • Fax | (623) 536-7385
Email | info@estrellafallsdentistry.com

# PATIENT INFORMATION FORM

## WELCOME

At Estrella Falls Dentistry, your dental health & smile are our top priorities. We are dedicated to providing you with the personalized, gentle care that you deserve.

**- PLEASE FILL OUT THIS FORM COMPLETELY. -**

---

## 1 About You

Name ______________________

Preferred Name ______________ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Birthdate / / Age_____ SS# ______________

Address ______________________

City ______________ State______ Zip________

Email ______________________

Home# ______________ Work# ______________

Mobile# ______________ Fax# ______________

How did you hear about us? ______________

Other family seen by us? ______________

Last visit date ______________

Employer ______________________

Employer# ______________ How long there? ________

## 2 Account Info

PERSON RESPONSIBLE FOR ACCOUNT

Name ______________ Relation ________

Home# ______________ Work# ______________

Mobile# ______________ Fax# ______________

Email ______________________

Billing Address ______________________

City ______________ State______ Zip________

## 3 Spouse Info

Name ______________________

Home# ______________ Work# ______________

Mobile# ______________ Birthdate / /

Email ______________________

## 4 Insurance

Provider Name ______________________

Provider Address ______________________

City ______________ State______ Zip________

Group# ______________________

Insured's Name ______________ Relation ________

Insured's Birthdate / / Insured's ID# ________

Insured's Employer ______________________

Insured's Ph# ______________________

### SECONDARY INSURANCE

Provider Name ______________________

Provider Address ______________________

City ______________ State______ Zip________

Group# ______________________

Insured's Name ______________ Relation ________

Insured's Birthdate / / Insured's ID# ________

Insured's Employer ______________________

Insured's Ph# ______________________

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# PATIENT INFORMATION FORM - CONT'D

## 5 Medical History

Your current physical condition ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription/over-the-counter or herbal supplement drugs? ☐ Yes ☐ No

Please list each one ______________________________

______________________________

Have you ever taken Bisphosphonates? ☐ Yes ☐ No

(Known as Fosamax, Actonel, etc.) if yes, when? __________

### FOR WOMEN ONLY

Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

### HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

| | | | | | |
|---|---|---|---|---|---|
| Y | N | Abnormal Bleeding | Y | N | Hepatitis |
| Y | N | Acid Reflux | Y | N | Herpes/Fever Blisters |
| Y | N | Alcohol/Drug Abuse | Y | N | High Blood Pressure |
| Y | N | Anemia | Y | N | HIV+/AIDS |
| Y | N | Arthritis | Y | N | Kidney Problems |
| Y | N | Artificial Bones, Joints or Valves | Y | N | Liver Disease |
| Y | N | Asthma | Y | N | Lupus |
| Y | N | Blood Transfusion | Y | N | Osteoporosis |
| Y | N | Cancer/Chemotherapy | Y | N | Pacemaker |
| Y | N | Colitis | Y | N | Psychiatric Care |
| Y | N | Congenital Heart Defect | Y | N | Radiation Treatment |
| Y | N | Diabetes | Y | N | Seizures |
| Y | N | Difficulty Breathing | Y | N | Sickle Cell Disease |
| Y | N | Dry Mouth | Y | N | Sinus Problems |
| Y | N | Emphysema | Y | N | Sleep Apnea/CPAP |
| Y | N | Epilepsy | Y | N | Stroke |
| Y | N | Fainting Spells | Y | N | Thyroid Problems |
| Y | N | Frequent Headaches | Y | N | Tuberculosis (TB) |
| Y | N | Glaucoma | Y | N | Ulcers |
| Y | N | Heart Attack | Y | N | Venereal Disease |
| Y | N | Heart Surgery | | | |
| Y | N | Hemophilia | | | |

Please list any medical condition not mentioned above:

______________________________

Have you ever been hospitalized for any reason? Please list why:

______________________________

### ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

| | | | | | |
|---|---|---|---|---|---|
| Y | N | Aspirin | Y | N | Jewelry/Metals |
| Y | N | Codeine | Y | N | Latex |
| Y | N | Dental Anesthetics | Y | N | Penicillin |
| Y | N | Erythromycin | Y | N | Tetracycline |

Please list any allergies not mentioned above:

______________________________

## 6 Medical Info

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: ______________________________

______________________________

Physician's Name ______________________________

Phone# __________________ Last Visit Date / /

### IN THE EVENT OF AN EMERGENCY, WHO SHOULD WE CONTACT?

Name______________________ Relation __________

Home# ______________ Work# ______________

## 7 Dental History

Why have you come to the dentist today? ______________

______________________________

Has your doctor told you that you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Your current dental health is? ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

How many times a week do you use floss? ______________

How many times a day do you brush?______________

Type of toothbrush bristles? ☐ Hard ☐ Medium ☐ Soft

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# WELCOME PAGE - Q&A

## We warmly welcome you.

To better serve you, please take just a couple minutes to answer the following questions. Thanks!

**What are the most important things to you about your smile and dental health?** ______________________

______________________________________________

**Do you smoke, vape or use chewing tobacco?** ☐ Yes ☐ No

If yes, how much? ______________________

And, for how long? ______________________

**Please check any of the following problems that apply to you:**

- ☐ Sensitivity (hot, cold or sweet)
- ☐ Headaches, earaches, neck pain
- ☐ Grinding or clenching teeth
- ☐ Lock jaw
- ☐ Teeth or fillings breaking
- ☐ Bleeding, swollen, or irritated gums
- ☐ Loose, tipped, or shifting teeth
- ☐ Bad breath
- ☐ Snoring

**Do you have or have you had any of the following?**

- ☐ Dentures or Partials
- ☐ Nightguard
- ☐ Orthodontics (retainers)
- ☐ Periodontal (gum) treatments or surgery
- ☐ Extractions or jaw surgery

**Please share the following approximate dates:**

Your last cleaning ______________________

Your last oral cancer screening ______________________

Your last complete x-rays ______________________

**Who was your previous dentist?**

Name: ______________________

City: ______________________ State: __________

Phone: ______________________

**Why did you leave your previous dentist?**

______________________________________________

**If you could change your smile, would you:**
(Please check all that apply)

- ☐ Make your teeth whiter
- ☐ Make your teeth straighter
- ☐ Close spaces between teeth
- ☐ Replace black metal fillings with tooth-colored restorations
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

**On a scale of 1 to 5, with 5 being the highest rating:**
(Please circle the numbers that best applies)

How important is your dental health to you?

1 2 3 4 5

How would you rate your current dental health?

1 2 3 4 5

Where do you want your dental health care to be?

1 2 3 4 5

**What is the most important thing to you about your dental visit today?** ______________________

______________________________________________

______________________________________________

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# PATIENT ACKNOWLEDGEMENTS

## 8 Disclaimer

I understand that the information I have given today is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my medical & insurance status. I also understand that this information will be held in the strictest of confidence. I authorize the dental team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Since payment is due in full at the time of treatment (unless other arrangements have been approved), I am responsible for any amount not covered by my insurance. For all patient balances that become older than 90 days, I agree to pay a late charge of 18% (per annum) added to the balance of the account. Outstanding balances may be sent to a collections agency; I agreed to pay all costs associated with collections and attorney fees if suit be instituted hereunder. I understand that a returned check will result in a $30 fee. If I need to reschedule an appointment, I will do everything within my power to give at least a 48 hour notice. I realize that failure to do so may result in a $50 fee.

Signature______________________________ Date __________

## 9 Privacy Practices

**Jay Suaverdez, D.D.S.**

ACKNOWLEDGEMENT OF NOTICE
OF PRIVACY PRACTICES

****You may refuse to sign this acknowledgement****

I, ________________________________________, understand that Dr. Suaverdez's Office abides by the HIPAA Law and will protect the privacy of my personal information.

Please Print Name________________________________________

Signature ______________________________________________

Date__________________

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement for the receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign.

____ Communication barriers prohibited us from obtaining acknowledgement.

____ An emergency situation prevented us from obtaining acknowledgment.

____ Other (Please Specify)

# Thank You!

We appreciate you for filling out this form completely. It will allow us to serve you more effectively.