STETSON VILLAGE FAMILY DENTISTRY

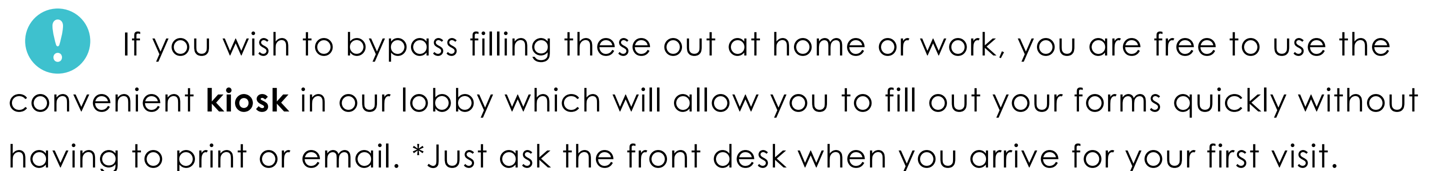
WELCOME TO OUR OFFICE!

Stetson Village Family Dentistry proudly serves several communities in the north central valley and surrounding areas. We provide exceptional general dentistry for your entire family, including cosmetic and implant dentistry.

Our mission is to help you achieve your best smile by not only having some pretty amazing hygienists to keep your teeth healthy and clean but also provide you with options to perfect your smile with cosmetic dentistry like Invisalign, take-home and same-day whitening, and single visit CEREC crowns.

Our friendly and competent staff are experts in providing comfort and quality care. With a gentle, family-oriented approach, we use the latest and greatest in dental technology and treatment options, as well as the most advanced equipment sterilization available process. We offer care that is comfortable and convenient for you and your entire family.

We look forward to welcoming you to our dental family!
Please fill out the following new patient forms to the best of your ability. You can download them to your computer, fill them out with any PDF reader and then email them to us.



If you wish to bypass filling these out at home or work, you are free to use the convenient **kiosk** in our lobby which will allow you to fill out your forms quickly without having to print or email. *Just ask the front desk when you arrive for your first visit.

3870 W Happy Valley #154, Glendale, AZ 85310 - **623-533-4895**

PATIENT REGISTRATION

ID: ________________ Chart ID: ________________

First Name: ______________________ Last Name: ______________________ Middle Initial: ____

Patient Is: ☐ Policy Holder ☐ Responsible Party   Preferred Name: ______________________

Responsible Party (if someone other than the patient)

First Name: ______________________ Last Name: ______________________ Middle Initial: ____

Address: ______________________ Address 2: ______________________

City, State, Zip: ______________________ Pager: ______________________

Home Phone: ____________ Work Phone: ____________ Ext: ________ Cellular: ____________

Birth Date: ____________ Soc Sec: ____________ Drivers Lic: ____________

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: ______________________ Address 2: ______________________

City: ____________ State, Zip ________ ____________ Pager: ____________

Home Phone: ____________ Work Phone: ____________ Ext: ________ Cellular: ____________

Sex: ◯ Male ◯ Female   Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: ____________ Age: ______ Soc Sec: ____________ Drivers Lic: ____________

E-mail: ______________________ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part-time

Medicaid ID: ____________ Pref. Dentist: ____________

Employer ID: ____________ Pref. Pharmacy ____________

Carrier ID: ____________ Pref. Hyg.: ____________

Section 3

Referred By: ____________

Previous Dentist: ____________

Emergency Contact: ____________

Emergency Contact #: ____________

Primary Insurance Information

Name of Insured: ______________________ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: ____________ Insured Birth Date: ____________

Employer: ______________________

Address: ______________________

Address 2: ______________________

City, State, Zip: ______________________

Rem. Benefits: ____________.00 Rem. Deduct: ____________.00

Ins. Company: ______________________

Address: ______________________

Address 2: ______________________

City, State, Zip: ______________________

Primary Insurance Information

Name of Insured: ______________________ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: ____________ Insured Birth Date: ____________

Employer: ______________________

Address: ______________________

Address 2: ______________________

City, State, Zip: ______________________

Rem. Benefits: ____________.00 Rem. Deduct: ____________.00

Ins. Company: ______________________

Address: ______________________

Address 2: ______________________

City, State, Zip: ______________________

MEDICAL HISTORY

PATIENT NAME: ______________________ BIRTH DATE: ______________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯Yes ◯No If yes, please explain: ______________________

Have you ever been hospitalized or had a major operation? ◯Yes ◯No If yes, please explain: ______________________

Have you ever had a serious head or neck injury? ◯Yes ◯No If yes, please explain: ______________________

Are you taking any medications, pills, or drugs? ◯Yes ◯No If yes, please explain: ______________________

Do you take, or have you taken, Phen-Fen or Redux? ◯Yes ◯No ______________________

Have you ever taken Fosamax, Bon iva, Actonel or any other medications containing bisphosphonates? ◯Yes ◯No ______________________

Are you on a special diet? ◯Yes ◯No

Do you use tobacco? ◯Yes ◯No

Do you use controlled substances? ◯Yes ◯No

Women: Are you

Pregnant / Trying to get pregnant? ◯Yes ◯No Taking oral contraceptives? ◯Yes ◯No Nursing? ◯Yes ◯No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs

☐ Other If yes, please explain ______________________

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

Condition	Yes	No
AIDS/HIV Positive	◯Yes	◯No
Alzheimer's Disease	◯Yes	◯No
Anaphylaxis	◯Yes	◯No
Anemia	◯Yes	◯No
Angina	◯Yes	◯No
Arthritis/Gout	◯Yes	◯No
Artificial Heart Valve	◯Yes	◯No
Artificial Joint	◯Yes	◯No
Asthma	◯Yes	◯No
Blood Disease	◯Yes	◯No
Blood Transfusion	◯Yes	◯No
Breathing Problem	◯Yes	◯No
Bruise Easily	◯Yes	◯No
Cancer	◯Yes	◯No
Chemotherapy	◯Yes	◯No
Chest Pains	◯Yes	◯No
Cold Sores/Fever Blisters	◯Yes	◯No
Congenital Heart Disorder	◯Yes	◯No
Convulsions	◯Yes	◯No
Cortisone Medicine	◯Yes	◯No
Diabetes	◯Yes	◯No
Drug Addiction	◯Yes	◯No
Easily Winded	◯Yes	◯No
Emphysema	◯Yes	◯No
Epilepsy or Seizures	◯Yes	◯No
Excessive Bleeding	◯Yes	◯No
Excessive Thirst	◯Yes	◯No
Fainting Spells/Dizziness	◯Yes	◯No
Frequent Cough	◯Yes	◯No
Frequent Diarrhea	◯Yes	◯No
Frequent Headaches	◯Yes	◯No
Genital Herpes	◯Yes	◯No
Glaucoma	◯Yes	◯No
Hay Fever	◯Yes	◯No
Heart Attack/Failure	◯Yes	◯No
Heart Murmur	◯Yes	◯No
Heart Pacemaker	◯Yes	◯No
Heart Trouble/Disease	◯Yes	◯No
Hemophilia	◯Yes	◯No
Hepatitis A	◯Yes	◯No
Hepatitis B or C	◯Yes	◯No
Herpes	◯Yes	◯No
High Blood Pressure	◯Yes	◯No
High Cholesterol	◯Yes	◯No
Hives or Rash	◯Yes	◯No
Hypoglycemia	◯Yes	◯No
Irregular Heartbeat	◯Yes	◯No
Kidney Problems	◯Yes	◯No
Leukemia	◯Yes	◯No
Liver Disease	◯Yes	◯No
Blood Pressure	◯Yes	◯No
Lung Disease	◯Yes	◯No
Mitral Valve Prolapse	◯Yes	◯No
Osteoporosis	◯Yes	◯No
Pain in Jaw Joints	◯Yes	◯No
Parathyroid Disease	◯Yes	◯No
Psychiatric Care	◯Yes	◯No
Radiation Treatments	◯Yes	◯No
Recent Weight Loss	◯Yes	◯No
Renal Dialysis	◯Yes	◯No
Rheumatic Fever	◯Yes	◯No
Rheumatism	◯Yes	◯No
Scarlet Fever	◯Yes	◯No
Shingles	◯Yes	◯No
Sickle Cell Disease	◯Yes	◯No
Sinus Trouble	◯Yes	◯No
Spina Bifida	◯Yes	◯No
Stomach/Intestinal Disease	◯Yes	◯No
Stroke	◯Yes	◯No
Swelling of Limbs	◯Yes	◯No
Thyroid Disease	◯Yes	◯No
Tonsillitis	◯Yes	◯No
Tuberculosis	◯Yes	◯No
Tumors or Growths	◯Yes	◯No
Ulcers	◯Yes	◯No
Venereal Disease	◯Yes	◯No
Yellow Jaundice	◯Yes	◯No

Have you ever had any serious illness not listed above? ◯Yes ◯No

Comments: ______________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________ **DATE** ______________________

DR. TONY BROCK

3870 W Happy Valley #154, Glendale, AZ 85310 - **623-533-4895**

HIPAA CONSENT

HEALTH INSURANCE PROBABILITY AND ACCOUNTABILITY ACT

I hereby give my consent for Stetson Village Family Dentistry to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO) as outlined in the Notice of Privacy Practices. The Notice of Privacy Practices describes such uses and disclosures more completely and is available for review upon request.

Stetson Village Family Dentistry reserves the right to revise its Notice of Privacy Practices at any time. A revised notice may be obtained upon forwarding a written request to 3870 West Happy Valley Road, Suite 154, Glendale, AZ 85310.

With this consent, Stetson Village Family Dentistry may call my home or alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, patient statements or letters.

With this consent, Stetson Village Family Dentistry may email my home or alternative location any items that assist in carrying out TPO such as appointment, reminders and statements. I have the right to request Stetson Village Family Dentistry restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Stetson Village Family Dentistry to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Stetson Village Family Dentistry may decline treatment to me.

____________________	________________	________
Signature of Patient/Legal Guardian	**Print Name**	**Date**

FINANCIAL POLICY

STETSON VILLAGE FAMILY DENTISTRY

At Stetson Village Family Dentistry we strive to deliver the finest quality dental care possible. In addition, we are also dedicated to making this top quality care as cost-effective as possible. We will always inform you of what the fee for your treatment will be prior to initiation.

Payment Options: Payment for all services is due at the time services are rendered unless an alternate payment agreement has been reached and signed by both parties. To assist you with your healthcare, we offer a variety of payment options including: cash, check, Visa, MasterCard, Discover and American Express. Extended and interest free payment plans (credit approval required) are also available.

Financial Terms:

- A $45.00 fee for appointments that are failed or canceled without 48-hours notice may be assessed.
- In order to reserve time with the doctor for treatment, a reservation fee may be required
- There will be a $25.00 charge for non-sufficient funds checks
- Any unpaid balances, including insurance over 60 days are subject to a 1.5% monthly finance charge.
- Stetson Village Family Dentistry reserves the right to charge a collection fee of 35% of the principal balance at the time of write off or dismissal to a third-party collection agency.

Signature of Patient/Legal Guardian	Print Name	Date

MEDIA RELEASE

STETSON VILLAGE FAMILY DENTISTRY

I hereby authorize Stetson Village Family Dentistry, hereafter referred to as "Company," to publish photographs taken of me on and my name and likeness, for use in the Stetson Village Family Dentistry print, online, social media and video-based marketing materials, as well as other Company publications.

I hereby release and hold harmless Stetson Village Family Dentistry from any reasonable expectation of privacy or confidentiality associated with the images specified above.

I further acknowledge that my participation is voluntary and that I will not receive financial compensation of any type associated with the taking or publication of these photographs or participation in company marketing materials or other Company publications. I acknowledge and agree that
publication of said photos confers no rights of ownership or royalties whatsoever.

I hereby release Stetson Village Family Dentistry, its contractors, its employees, and any third parties involved in the creation or publication of marketing materials, from liability for any claims by me or any third party in connection with my participation.

Authorization

Printed Name: ____________________________

Signature: ________________________________ **Date:** ______________________

Parent or legal Guardian name: _____________________________________

Signature: ________________________________ **Date:** ______________________