DR. PEASE & ASSOCIATES

DENTIST • DENTURE LAB

4830 E. Main St. #23 Mesa, AZ 85205 ● 2415 E. Main St. Mesa, AZ 85201

Patient Information ☐ Male ☐ Female ☐ Married ☐ Single

Name: First ______________________MI: ____ Last: ______________________

Date of Birth: __________________ Social Security #: ______________________

Address: ______________________________________ City/State/Zip: ____________

Home: __________________ Cell: __________________ Work: ________________

Email: ___________________________

Whom may we thank for referring you? ____________________________________

Insurance Information

Policy Holder: __________________________ I.D.#: ___________ D.O.B: __________

Insurance Carrier: ______________________ Employer: ______________Grp#:________

Dental History

Reason for today's dental visit: ____

Former Dentist: ____________________________ City/State: ________________

Date of Last Dental Visit: ______________________ Date of Last X-Rays: ___________

Have you had any of the following problems?

☐ Bleeding Gums ☐ Bad Breath ☐ Soreness in jaw joint ☐ Grinding of teeth

☐ Loose/broken fillings ☐ Blisters on lips/mouth ☐ Sensitivity to hot/cold ☐ Sores/growths in mouth

☐ Dry Mouth ☐ Burning sensation on tongue ☐ Clicking, popping or discomfort of jaw

Patient Name: ______________________________ **D.O.B.:** ____________________

Physician's Name: ______________________________ **Phone#:** ____________________

Has a physician recommended that you take antibiotics prior to your dental treatment? □ Yes □ No
Are you currently taking blood thinners? (Coumadin, Aspirin, Plavix, Warfarin, Xarelto, etc.) □ Yes □ No
Have you ever used a bisphosphonate medication? □ Yes □ No
Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? □ Yes □ No
Are you currently pregnant? □ Yes □ No

Please Check "Yes" or "No" to the following conditions:

Condition			Condition			Condition		
Allergy - Aspirin	□ Y	□ N	Cancer - Type:	□ Y	□ N	Low Blood Pressure	□ Y	□ N
Allergy - Barbiturates	□ Y	□ N	Circulatory Problems	□ Y	□ N	Mitral-Valve Prolapse	□ Y	□ N
Allergy - Codeine	□ Y	□ N	Cong. Heart Defects	□ Y	□ N	Mental Disorders	□ Y	□ N
Allergy - Iodine	□ Y	□ N	Cortisone Treatment	□ Y	□ N	Pacemaker	□ Y	□ N
Allergy - LATEX	□ Y	□ N	Diabetes	□ Y	□ N	Psychiatric Care	□ Y	□ N
Allergy - Local Anesthetic	□ Y	□ N	Epilepsy	□ Y	□ N	Respiratory Disease	□ Y	□ N
Allergy - Penicillin	□ Y	□ N	Emphysema	□ Y	□ N	Rheumatic Fever	□ Y	□ N
Allergy - Sulfa Drugs	□ Y	□ N	Fainting/Dizziness	□ Y	□ N	Radiation/Chemotherapy	□ Y	□ N
Allergy - Other	□ Y	□ N	Fever Blisters/ Sores	□ Y	□ N	Shortness of Breath	□ Y	□ N
AIDS / HIV	□ Y	□ N	Glaucoma	□ Y	□ N	Sinus Trouble	□ Y	□ N
Alzheimer's	□ Y	□ N	Hay Fever	□ Y	□ N	Scarlet Fever	□ Y	□ N
Asthma	□ Y	□ N	Herpes	□ Y	□ N	Stomach Problems	□ Y	□ N
Anemia	□ Y	□ N	Headaches	□ Y	□ N	Skin Rash/Special Diet	□ Y	□ N
Arthritis	□ Y	□ N	Heart Murmur	□ Y	□ N	Stroke	□ Y	□ N
Artificial Heart Valve	□ Y	□ N	Heart Disease	□ Y	□ N	Swollen ankles/feet	□ Y	□ N
Artificial Joints	□ Y	□N	Hepatitis Type(mark) A B C	□ Y	□ N	Swollen neck glands	□ Y	□ N
Blood Disease	□ Y	□ N	High Blood Pressure	□ Y	□ N	Thyroid Problems	□ Y	□ N
Back problems	□Y	□ N	Hypoglycemia	□ Y	□ N	Tonsillitis	□ Y	□ N
Bleeding Problems	□ Y	□ N	High Risk OCS	□ Y	□ N	Tumor - head/neck	□ Y	□ N
Chest Pain	□ Y	□ N	Jaw Pain	□ Y	□ N	Ulcer	□ Y	□ N
Cancer	□ Y	□ N	Jaundice	□ Y	□ N	Venereal Disease	□ Y	□ N
Chemical Addiction	□ Y	□ N	Kidney Disease	□ Y	□ N	Sensitive to Epinephrine	□ Y	□ N
Cough (persistent)	□ Y	□ N	Liver Disease	□ Y	□ N	Lung Disease	□ Y	□ N

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

Current List of Medications: ______________________________

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Pharmacy: ______________________________

Doctor Signature: ______________________________ **Date:** ______________

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& ASSOCIATES

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PATIENT FINANCIAL AGREEMENT

The following information is to inform you of our financial policy. If, at any time, you have questions regarding this policy, please do not hesitate to ask any member of our business team.

We are committed to providing you with the highest quality of care. Our fees are a reflection of the quality of care we provide. We continue our commitment by offering a variety of financial options to enable you to receive the dental care you need. We accept cash, check, VISA, MasterCard, Discover, and American Express. We have also partnered with a third-party company to offer the flexibility of deferred interest and extended payment options. Check policy: If your check is returned for any reason, we will electronically debit your account for the amount of the check plus a processing fee of $25.

We will communicate all recommended treatment options and associated fees, prior to the start of treatment. Payment is expected at the time of treatment. A delinquent account impedes our ability to provide you with the quality dental care that you deserve. It is our policy that the parent or guardian who accompanies a child to our office for treatment is responsible for payment of all services rendered.

We are committed to respecting your time and ask that you make every effort to keep the appointment time reserved exclusively for you. We understand there may be times when you are unable to keep your scheduled appointment, however, any appointment missed may be subject to a missed appointment fee of $25. Should you find it necessary to reschedule an appointment, please provide us with a notice of two business days to avoid being charged a missed appointment fee.

As a courtesy to our patients with dental insurance benefits, we will submit your claim and provide any necessary information to assist you in receiving your dental benefits. We require that any applicable deductibles and estimated patient portion be paid at the time treatment is rendered. We do accept assignment of insurance benefits as a form of payment to help reduce your immediate out-of-pocket expense. We are participating providers for select PPO networks.

Please contact your insurance carrier prior to your visit to obtain essential information which will accurately reflect your coverage. Providing us with this information will expedite the processing of claims. If you have a direct reimbursement policy, payment in full is expected on the day of service and your dental plan will reimburse you. It is important to understand that dental insurance is a contract between the patient and the insurance company. It is a benefit to assist you with the cost of dental care. At no time should insurance benefits compromise your doctor's diagnosis or affect your choice treatment. It is your responsibility to understand the type of dental insurance you have (i.e. Traditional, PPO or DMO), and the benefits selected by you and/or your employer. You (not the insurance company) are responsible for the fees of services rendered.

Signature of Patient or Guardian Date

4830 E MAIN ST, STE 23 MESA, AZ 85205 (480)832-3335 PHONE (480)832-4898 FAX

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Dr. Erik Pease and Associates are required by federal and state law to maintain the privacy of your health information. We are also required to give you this notice of privacy practices that are described in the notice while it is in effect. This notice takes place April 14, 2003 and will remain in effect until we replace it.

You have the right to review our privacy practices, the right to access any health information or amendments made to it. You also have the right to an accounting of disclosures and restrict uses of communicating health information.

We may use and disclose health information about you for treatment, payment, and health care operations (which does include communication with your general dentist or physician).

We will not use your health information for any manner of direct or indirect personal gain or other unauthorized use.

We may use or disclose your health information when we are required to do so by law.

We may disclose your health information to appropriate authorities if we reasonably believe that you are possible victim of abuse, neglect or domestic violence or the possible victim of other crimes.

We will not use or disclose your health information for any reason other than those listed without your written authorization.

We reserve the right to change our privacy practices and terms of this notice at any time, provided such changes are permitting by applicable law. For more information about our privacy practices, please contact our office manager at 480-832-3335.

I have read and understand Dr. Erik Pease and Associates privacy practices. I consent for Dr. Erik Pease and Associates to disclose my protected health information as described.

In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time.

☐ I authorize the use of my health information for any other purpose other than what is stated in the notice of privacy practice.

☐ I do not authorize the use of my protected health information for any other purpose other than what is stated in the notice of privacy practice.

Signature of Patient or Guardian Date