ARIEL E. TRUJILLO, DMD
Practice Limited to Periodontics
Dental Implantology

ARIZONA
Periodontal GROUP

ACCOUNT INFORMATION

Patient Information:

Last Name: _____ First: _____ Middle: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Referred By: _____

Home Phone: _____ Work or Cell Phone: _____

Date of Birth: _____ Social Security: _____

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____

Spouse/Guarantor Information:

Name: _____ Date of Birth: _____ Social Security: _____

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Insurance Information

Insurance Company 1: _____ Group/Policy: _____

Address: _____ ID# _____

Phone: _____ Policy Holder: _____

Insurance Company 2: _____ Group/Policy: _____

Address: _____ ID# _____

Phone: _____ Policy Holder: _____

To avoid any misunderstanding regarding dental insurance, we wish the persons responsible to know all professional services rendered to them are charged directly to them and they are responsible for all fees.

Signature of Responsible Party _____ **Date:** _____

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Patient Information (All Information is confidential)

Name: _____
(Last) (First) (Middle)

Marital Status: (check) ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Date of Birth: _____ Sex: _____ Height _____ Weight _____ Occupation _____

Person to contact in case of emergency: _____ Phone: _____

Referred by: _____ How long his/her patient _____

Medical Health (The information contained herein is considered confidential and is for our records only.)

General health (please check) ☐ Excellent ☐ Good ☐ Fair ☐ Poor Last Complete Physical _____

Name of physician: _____ Specialty: _____

City: _____ State: _____ Phone: _____

Name of physician: _____ Specialty: _____

City: _____ State: _____ Phone: _____

Name of physician: _____ Specialty: _____

City: _____ State: _____ Phone: _____

Health History

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   Why? _____
4. Yes No Are you being treated by a physician now? For what? _____
   Date of last Medical Exam: _____ Date of last dental appt: _____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

II. HAVE YOU EXPERIENCED:

7. Yes No Chest Pain (angina)?
8. Yes No Swollen ankles?
9. Yes No Shortness of breath?
10. Yes No Recent weight loss, fever, night sweats?
11. Yes No Persistent cough, coughing up blood?
12. Yes No Bleeding problems, bruising easily?
13. Yes No Sinus problems?
14. Yes No Difficulty swallowing?
15. Yes No Diarrhea, constipation, blood in stools?
16. Yes No Frequent vomiting, nausea?
17. Yes No Difficulty urinating, blood in urine?
18. Yes No Dizziness?
19. Yes No Ringing in the ears?
20. Yes No Headaches?
21. Yes No Fainting spells?
22. Yes No Blurred vision?
23. Yes No Seizures?
24. Yes No Excessive thirst?
25. Yes No Frequent urination?
26. Yes No Dry mouth?
27. Yes No Jaundice?
28. Yes No Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

29. Yes No Heart disease?
30. Yes No Heart attack, heart defects?
31. Yes No Heart murmurs?
32. Yes No Rheumatic fever?
33. Yes No Stroke, hardening of arteries?
34. Yes No High blood pressure?
35. Yes No TB, emphysema, lung diseases?
36. Yes No Hepatitis, other liver disease?
37. Yes No Stomach problems, ulcers?
38. Yes No Allergies to: drugs, foods, medications? _____
39. Yes No Family history of diabetes, heart problems, tumors?
40. Yes No HIV or AIDS?
41. Yes No Tumors, cancer?
42. Yes No Arthritis, rheumatism?
43. Yes No Eye disease? _____
44. Yes No Skin diseases? _____
45. Yes No Anemia?
46. Yes No STD?
47. Yes No Herpes?
48. Yes No Kidney, bladder disease?
49. Yes No Thyroid, adrenal disease?
50. Yes No Diabetes? Type _____

51. Yes No Psychiatric care?
52. Yes No Radiation treatments?
53. Yes No Chemotherapy?
54. Yes No Prosthetic heart valve?
55. Yes No Artificial joint?
56. Yes No Bronchitis or Asthma?
57. Yes No Hospitalization?
58. Yes No Blood transfusions?
59. Yes No Surgeries?
60. Yes No Pacemaker?
61. Yes No Contact lenses?
62. Yes No Osteoporosis?

IV. ARE YOU TAKING:

63. Yes No Recreational drugs?
64. Yes No Drugs, medicines, (incl. Aspirin)?
65. Yes No Tobacco in any form?
66. Yes No Alcohol?

Please List: _____

V. WOMEN ONLY:

67. Yes No Are you or could you be pregnant or nursing?
68. Yes No Taking birth control pills?

VI. ALL PATIENTS

69. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain: _____

Dental Health

Reason for visit: _____

When was your last dental visit? _____ Last cleaning? _____

Have you ever had any serious problem associated with previous dental treatment? Yes ☐ No ☐

If so, explain: _____

How often do you brush your teeth? _____

What texture brush do you use? Soft ☐ Medium ☐ Hard

How often do you floss? _____

Do your gums bleed while brushing? Yes ☐ No ☐

Do your gums bleed when flossing? Yes ☐ No ☐

Do you avoid brushing any part of your mouth because of pain? Yes ☐ No ☐

If yes, what part? _____

Do you feel twinges of pain when your teeth come in contact with:

a) hot food or liquids, i.e., soup, coffee, tea, etc.? Yes ☐ No ☐

b) cold foods or liquids, i.e., ice cream, cold fruit, etc.? Yes ☐ No ☐

c) sweets, i.e., candy, fruit, sweet desserts, etc.? Yes ☐ No ☐

d) sours, i.e., lemons, limes, grapefruit, etc.? Yes ☐ No ☐

Do you smoke? If yes, how much? _____

Do you use chewing tobacco? if yes, how much? _____

Do you feel pain to any of your teeth when brushing or flossing them? Yes ☐ No ☐

Do you chew on only one side of your mouth? Yes ☐ No ☐

If yes, explain: _____

Do your gums feel tender or swollen? Yes ☐ No ☐

Do you clench or grind your jaws while sleeping or during the day? Yes ☐ No ☐

Do your jaws ever feel tired? Yes ☐ No ☐

Do you think your teeth are moving or drifting? Yes ☐ No ☐

Are you familiar with the term periodontal disease? Yes ☐ No ☐

Have you ever been told that you had periodontal disease? Yes ☐ No ☐

Have you ever been treated for periodontal disease? Yes ☐ No ☐

I CERTIFY THE ABOVE TO BE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

Patient signature: _____ Date: _____

Diagnosis and Treatment Plan

Name:

Clinical Examination

Blood pressure: ______________________ Medication: ______________________

Soft tissues of head and neck: ______________________

Oral mucosa: ______________________

Teeth: ______________________

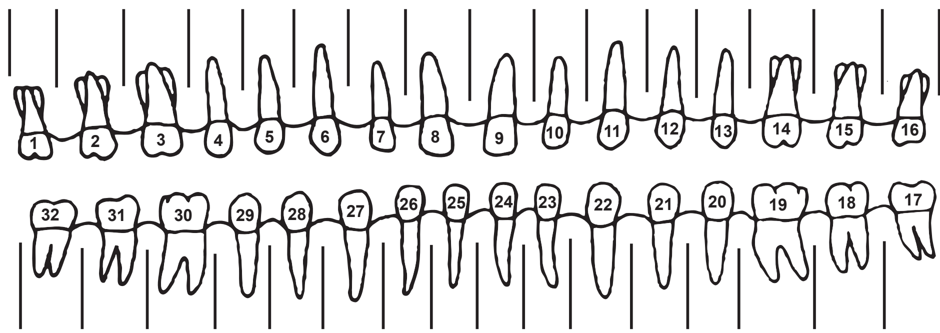
Gingiva: ______________________

Occlusion: ______________________

TMJ: ______________________

Oral hygiene: ______________

Perio Type: ______________



Name:

Treatment Record

Date	Tooth Quad	Procedure	Initial

Date	Tooth Quad	Procedure	Initial

Arizona Periodontal Group Financial Policy

1. It is our policy to make definite and clear financial arrangements prior to beginning any treatment. We are in network and/or a participating provider with some insurance companies not all of them. We will help you to maximize your dental benefits in our office. Please bring your insurance card with you at the initial exam!

2. Our fees are reasonable and customary for quality care in this area, but as different insurance companies use different fee schedules (which vary greatly), we may or may not fall within what they consider to be usual and customary. You are responsible for paying all charges not covered by your insurance company.

3. Please remember that insurance is a contract between you and the insurance company. Despite verification by phone or written pre-authorization, your carrier may still deny payment on a claim.

4. We accept Cash, Check, Debit, Visa, Mastercard, Discover, American Express, and Care Credit. There is a $50.00 returned check fee.

5. Often times patients find it to be convenient for them to keep a credit card on file for balances over 60 days to be charged to. Is this something you would like to do? **YES / NO**. If yes, please provide CC# and Expiration Date_____

6. We have a 24-hour cancellation policy. We reserve the right to charge a fee of $75 per hour scheduled if less than 24 hours notice is given.

7. In the event that an account becomes delinquent, you will be responsible for all legal and administrative fees involved in collecting monies owed.

8. The parent or guardian who brings a child for an appointment is responsible for paying the patient portion and any prior balance at that visit.

By signing below I acknowledge:

1. I have read, understand and accept all conditions of this financial policy.

2. I certify that I have insurance coverage if indicated above, and assign directly to Arizona Periodontal Group, LLC all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by my insurance. I understand the office will assist with insurance submissions. I hereby authorize Arizona Periodontal Group, LLC to release all information necessary to secure the payment of benefits. I also authorize the use of this signature on all insurance forms.

3. I authorize Arizona Periodontal Group, LLC to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I also authorize release of any information, including diagnosis and the records of any treatment or examinations rendered to my dependent or me during the period of such care to third party payors and/or health practitioners.

If opted, I authorize Arizona Periodontal Group, LLC to charge balances over 60 days to the credit card on file that I have provided above.

Signature_____ Date _____

Print Name _____

Business Assistant _____

ARIZONA PERIODONTAL GROUP

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:_____

E-Mail: _____ Telephone: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available upon request. We do encourage you to read it carefully and completely.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting:

Contact Person: Business Assistant
Telephone: 602-995-5045 Fax: 602-995-3222
Address: 1717 W. Northern Ave, Ste #104, Phoenix, AZ 85021

Right to revoke: You will have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of the Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____