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: ____________

Acknowledgement of Patient Financial Responsibility

Here at Arizona Periodontal Group, we offer expert assistance through our insurance department to help you and your dependants maximize your dental insurance benefits. We will provide you as much information as possible regarding your policy. However, payment for services are always the responsibility of the policy holder. You are responsible for any amounts not covered under your dental policy.

1. I agree to pay any portion of my treatment fees not covered by my insurance company. I understand any prior balance on my account must be paid before any future services are rendered. We accept cash, check, credit card and Care Credit.

2. I understand Arizona Periodontal Group can only offer me an estimate of benefits for my treatment. I understand I have the right to request a written pre-authorization of treatment to be sent to my insurance company prior to having services rendered. By sending a written authorization I understand I am delaying my recommended treatment plan which may alter my treatment if too much time passes. Treatment plans are based on the quality of individual patient care, not by the standards set by insurance companies.

3. I understand it is my responsibility to be knowledgeable of the pay guidelines/limitations set for periodontal maintenance cleanings under my insurance policy. Periodontal maintenance cleaning recommendations are based on the quality of individual patient care, not by the standards set by insurance companies.

4. I understand if my treatment is started but not completed by Arizona Periodontal Group and a lab fee was incurred, the office has the right to adjust the balance on my account and charge for lab fees including doctor time. Any monies collected will be applied to these charges before a refund is issued.

5. I understand Arizona Periodontal Group has a 24 hour cancellation policy and will charge a minimum of $50 per hour (based off of appointment time) to me if my appointment is cancelled or rescheduled within 24 business hours of the appointment time. I understand I am responsible to pay these fees on or at my next scheduled appointment.
Our office hours are Monday 8am-2pm, Tuesday through Thursday 8am - 5pm, and Fridays 8am - 2pm.

6. Arizona Periodontal Group is happy to provide duplicates of your x-rays or clinical notes at a fee of $25 upon a written request from the patient or legal guardian. I understand it may take up to 48 business hours to duplicate records.

____ ______________________

Signature of Patient or Guardian Date

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: ____