Moon Valley Dentistry

1930 West Thunderbird Road Suite #116,
Phoenix, AZ 85023
Phone: (602)993-3744 Fax: (602)993-3745
www.MoonValleyDentistry.com

PATIENT REGISTRATION

YOU

LAST NAME | FIRST | M.I. | NICKNAME

ADDRESS | CITY, STATE | ZIP

HOME PHONE | CELL | *EMAIL

BIRTHDATE | AGE | SOC.SEC. # *IF NONE, CASH OR CC ONLY*

DRIVER'S LICENSE # | STATE | PLEASE PRESENT YOUR DRIYER'S LIC. FOR VERIFICATION

OCCUPATION | EMPLOYER'S NAME

EMP. ADDRESS | EMP. PHONE | FAX #

CHILD

LAST NAME | FIRST | M.I. | NICKNAME

ADDRESS | CITY, STATE | ZIP

HOME PHONE | DATE OF BIRTH | SOCIAL SECURITY NUMBER

SCHOOL | GRADE

INSURANCE

INSURANCE COMPANY | GROUP NUMBER | EMPLOYER NAME

INSURED'S NAME | DATE OF BIRTH | RELATIONSHIP TO PATIENT

INSURED'S ID # | INSURED'S SOCIAL SECURITY # | ***MUST HAVE THIS

SECONDARY INSURANCE COMPANY | GROUP NUMBER | EMPLOYER NAME

INSURED'S NAME | DATE OF BIRTH | RELATIONSHIP TO PATIENT

INSURED'S ID # | INSURED'S SOCIAL SECURITY #

EMERGENCY CONTACT

NAME | RELATIONSHIP

ADDRESS | PHONE #

PERSON FINANCIALLY RESPONSIBLE FOR YOUR ACCOUNT

*YOU _____ YOUR SPOUSE _____ OTHER _____

NAME | ADDRESS | PHONE

RELATIONSHIP TO PATIENT | SOCIAL SECURITY # | DRIVER'S LICENSE #

OCCUPATION | EMPLOYER'S NAME

EMP. ADDRESS | EMP. PHONE | FAX #

HOW DID YOU HEAR OF US?

FRIEND OR FAMILY _____

MEDICAL HISTORY

EXISTING CUSTOMER_____ YELLOW PGS_____ INTERNET_____ SIGN _____ OTHER_____

Although dental personnel primarily treat the area in and around your mouth is a part of your entire body. Health problem 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 _____
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 ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: _____

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

AIDS/HIV Positive	OYesONo	Cortisone Medicine	OYesONo	Hemophilia	OYesONo	Renal Dialysis	OYesONo
Alzheimer's Disease	OYesONo	Diabetes	OYesONo	Hepatitis A	OYesONo	Rheumatic Fever	OYesONo
Anaphylaxis	OYesONo	Drug Addiction	OYesONo	Hepatitis B or C	OYesONo	Rheumatism	OYesONo
Anemia	OYesONo	Easily Winded	OYesONo	Herpes	OYesONo	Scarlet Fever	OYesONo
Angina	OYesONo	Emphysema	OYesONo	High Blood Pressure	OYesONo	Shingles	OYesONo
Arthritis/Gout	OYesONo	Epilepsy or Seizures	OYesONo	Hives or Rash	OYesONo	Sickle Cell Disease	OYesONo
Artificial Heart Valve	OYesONo	Excessive Bleeding	OYesONo	Hypoglycemia	OYesONo	Sinus Trouble	OYesONo
Artificial Joint	OYesONo	Excessive Thirst	OYesONo	Irregular Heartbeat	OYesONo	Spina Bifida	OYesONo
Asthma	OYesONo	Fainting Spells/Dizziness	OYesONo	Kidney Problems	OYesONo	Stomach/intestinal Disease	OYesONo
Blood Disease	OYesONo	Frequent Cough	OYesONo	Leukemia	OYesONo	Stroke	OYesONo
Blood Transfusion	OYesONo	Frequent Diarrhea	OYesONo	Liver Disease	OYesONo	Swelling of Limbs	OYesONo
Breathing Problem	OYesONo	Frequent Headaches	OYesONo	Low Blood Pressure	OYesONo	Thyroid Disease	OYesONo
Bruise Easily	OYesONo	Genital Herpes	OYesONo	Lung Disease	OYesONo	Tonsillitis	OYesONo
Cancer	OYesONo	Glaucoma	OYesONo	Mitral Valve Prolapse	OYesONo	Tuberculosis	OYesONo
Chemotherapy	OYesONo	Hay Fever	OYesONo	Pain in Jaw Joints	OYesONo	Tumors or Growths	OYesONo
Chest Pains	OYesONo	Heart Attack/Failure	OYesONo	Parathyroid Disease	OYesONo	Ulcers	OYesONo
Cold Sores/Fever Blisters	OYesONo	Heart Murmur	OYesONo	Psychiatric Care	OYesONo	Venereal Disease	OYesONo
Congenital Heart Disorder	OYesONo	Heart Pace Maker	OYesONo	Radiation Treatments	OYesONo	Yellow Jaundice	OYesONo
Convulsions	OYesONo	Heart Trouble/Disease	OYesONo	Recent Weight Loss	OYesONo		OYesONo

Have you ever had any serious illness not listed above? ◯Yes ◯No If yes, please explain: _____

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 _____

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INFORMED CONSENT & FINANCIAL POLICY

Please INITIAL each line:

_____I understand that the information I have given today is correct to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in any medical status. I authorize the dental staff to perform any necessary dental services, such as x-rays, study models, photographs or any other diagnostic aid deemed appropriate by the doctor to make a thorough diagnosis. I also authorize the doctor (and his employees for assistance where applicable) to perform any and all forms of treatment, medication and therapy with my informed consent in connection with my diagnosis and treatment plan.

_____**Payment is required on the day of your visit.** We accept cash, personal check or major credit card (Visa, MasterCard, Am Ex, Discover). We also offer the option to arrange financing for services through outside companies.

_____We do our best to estimate the patient portion of your bill and that estimated amount is due at the time of your treatment. Any amount left owing after insurance has paid will be billed to you immediately and is due within 10 days of the statement. Balances left after 30 days will incur an 18% APR service charge. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collections fees. If you have any questions about this policy, please ask one of our staff members before you receive treatment.

_____We also reserve the right to charge for appointments cancelled or broken without 24 hour notice at a rate of $50 per appointment, or $50 per hour whichever is greater. *Receiving payment at the time of service and keeping your appointment helps keep our costs and thus our fees down.

Patient Name (Printed) Patient/Parent or Guardian Signature Date

IF YOU HAVE DENTAL INSURANCE: PATIENT AUTHORIZED SIGNATURE FORM

Please INITIAL each line:

_____The under signed here by authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits for services rendered or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

_____We do accept most Preferred Provider Organization (PPO) insurance, plans, but are not IN-NETWORK with all of them. We are still very happy to file on your PPO as an OUT-OF-NETWORK provider, but the patient is responsible for any difference between our fee and the amount insurance pays. Many times, there is not much difference between IN-NETWORK and OUT-OF-NETWORK coverage. A large number of our patients who are OUTOF-NETWORK realize that choosing the best dental treatment available for them is worth the occasional slightly higher co-pay.

_____I understand I am financially responsible to Moon Valley Dentistry for charges not covered by this assignment. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collections fees. Please remember that benefits coverage is a legal agreement between you and your insurance company. Our office is not involved in that agreement and your dental treatment is determined by your oral health, not your insurance company's reimbursement schedule. For the most accurate information regarding your benefits, please contact your insurance provider.

Authorized Signature of Covered Person/ Parent Date

PRIVACY/ HIPPA NOTICE ☐ Received ☐ Declined Initials Date