Your Health is Our Priority

Your health and safety are our main priority and we want you to feel assured that when you come into our office you won't be exposed to the Corona virus or any other communicable illnesses. In addition to our current and standard infection control practices, our team will be implementing the following additional measures and screening procedures for both patients and the team members, to ensure your health and safety.

PATIENTS:

All patients will be thoroughly screened by phone before their reserved appointment. The current protocol is to screen patients by questions regarding contact and exposure of Covid-19.

Upon arrival, we ask that patients call our office from their car, to alert us that they have arrived for their appointment.

Patients will be informed to wait in their car until a staff member is ready and comes out to get them. ONLY PATIENTS will be allowed in the office unless accompanied by a guardian. Also, we ask that patients do not bring any outside food or drink items into the practice.

Only limited number of patients will be allowed in the waiting room at a time.

As much as we enjoy spending time with our patients during their dental visit, we ask that you respect social distancing requirements by avoiding contact with others such as hand-shaking, hugging, touching or sharing non-treatment related items.

For better control of contact areas, all treatment plan presentations will be completed while the patient is seated in the treatment area. Future appointment scheduling and payments will be made at the front counter behind the plexiglass.

EVDP TEAM:

All team members and patients will complete the daily screening procedures.

Every half hour our team will complete a "disinfectant sweep" by disinfecting all door handles, desk areas and bathrooms with sanitizing wipes.

We are committed to maintaining OSHA and CDC infection control guidelines within our practice and will ensure all team members are equipped with the PPE required to protect both our patients and our team.

As part of our dental family, we value our commitment to deliver quality lifetime dentistry.

Thank you for your continued patience as we strive to serve and support you in the best possible way.

- Your East Valley Dental Professionals Team -

WELCOME TO EAST VALLEY DENTAL PROFESSIONALS

Name ______________________ Nickname ______________________
Address ______________________ Unit# ____________
City ______________________ State ____________ Zip ______________
Cell # ______________ Home # ______________ Work # ______________
E-Mail ______________________ Birthdate ____________ Age _____ Sex ____
Social Sec # ______________________ Single __ Married __ Widowed __ Other _____
Employer ______________________ Occupation ______________________
How did you hear about our office? ______________________
Person to notify in case of emergency ______________________ Phone ____________

INSURANCE INFORMATION

Name of your **Primary Dental Insurance**

____

Policy Holder's Name ______________________
Relationship to Patient ______________________
Insured's Birth Date ______________________
Social Security # ______________________
Insurance ID# (If different from SS#) ______________________
Claim Address ______________________
____
____
Insurance Phone # ______________________
Group # ______________________

Name of your **Secondary Dental Insurance**

____

Policy Holder's Name ______________________
Relationship to Patient ______________________
Insured's Birth Date ______________________
Insured's SS# ______________________
Insurance ID# (If different from SS#) ______________________
Claim Address ______________________
____
____
Insurance Phone # ______________________
Group # ______________________

DENTAL HISTORY

REASON FOR TODAY'S VISIT ______________________
____
FORMER DENTIST ______________________
CITY/STATE ______________________
DATE OF LAST DENTAL CARE ______________________
DATE OF LAST DENTAL XRAYS ______________________
PLEASE INDICATE IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

___BAD BREATH
___BLEEDING GUMS
___BLISTERS ON LIPS OR MOUTH
___BURNING SENSATION ON TONGUE
___CHEW ON ONE SIDE OF THE MOUTH
___CIGARETTE, PIPE, OR CIGAR SMOKING
___CLICKING OR POPPING IN JAW
___DRY MOUTH
___FINGERNAIL BITING
___FOOD COLLECTION BETWEEN TEETH
___FOREIGN OBJECTS
___GRINDING TEETH
___GUMS SWOLLEN OR TENDER
___JAW PAIN OR TIREDNESS
___LIP OR CHEEK BITING
___LOOSE TEETH OR BROKEN FILLINGS
___MOUTH BREATHING
___MOUTH PAIN WITH BRUSHING
___ORTHODONTIC TREATMENT
___PAIN AROUND EAR
___PERIODONTAL TREATMENT
___SENSITIVITY TO COLD
___SENSITIVITY TO HEAT
___SENSITIVITY TO SWEETS
___SENSITIVITY WHEN BITING
___SORES OR GROWTHS IN MOUTH
___TOBACCO, SMOKELESS / OTHER

HOW OFTEN DO YOU BRUSH?
____
HOW OFTEN DO YOU FLOSS?
____

Are you dissatisfied with your teeth, &/or their appearance?

____

Anything you would change about your smile?

____

EAST VALLEY DENTAL PROFESSIONALS

Patient ______________________________ **Birthdate** _______________ **Sex** _____

Cell Phone ____________________________ **Email** ___________________________

Street ________________________________ **City** _______________ **Zip** __________

INSURANCE CO: _________________________ **Insurance Effective Date:** _____________

HEALTH HISTORY

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionamin, Adipex, Fastin (brand names of phentermine) and Redux (dexfenfluramine)? [ ] YES [ ] NO

Have you ever taken or are you taking any Bisphosphonate(brand names Fosamax, Actonel, Boniva)? [ ] YES [ ] NO

Place a mark to indicate if you have, or have had in the past, any of the following:

___AIDS/HIV
___ANEMIA
___ARTHRITIS, RHEUMATISM
___ARTIFICIAL HEART VALVE
___ARTIFICIAL JOINTS
___ASTHMA
___BACK PROBLEMS
___BLEEDING ABNORMALLY, W/ SURGERY, EXTRACTIONS
___BLOOD DISEASE
___CANCER
___CHEMICAL DEPENDANCY
___CHEMOTHERAPY
___CIRCULATORY PROBLEMS
___CONGENITAL HEART LESIONS
___CORTISONE TREATMENTS
___COUGH, PERSISTENT
___DIABETES
___EMPHYSEMA
___EPILEPSY
___FAINTING OR DIZZINESS
___GLAUCOMA
___HEADACHES
___HEART MURMUR
___HEART PROBLEMS
___HEPATITIS TYPE ___
___HERPES
___HIGH BLOOD PRESSURE
___JAUNDICE
___JAW PAIN
___KIDNEY DISEASE
___LIVER DISEASE
___LOW BLOOD PRESSURE
___MITRAL VALVE PROLAPSE
___NERVOUS PROBLEMS
___PACEMAKER
___PSYCHIATRIC CARE
___RADIATION TREATMENT
___RESPIRATORY DISEASE
___RHEUMATIC FEVER
___SCARLET FEVER
___SHORTNESS OF BREATH
___SINUS TROUBLE
___SKIN RASH
___SPECIAL DIETARY NEEDS
___STROKE
___SWOLLEN FEET OR ANKLES
___SWOLLEN NECK GLANDS
___THYROID PROBLEMS
___TOBACCO USE
___TONSILLITIS
___TUBERCULOSIS
___TUMOR OR GROWTH
___ULCER
___VENEREAL DISEASE

Do you wear contact lenses? [ ] Yes [ ] No

WOMEN: Are you pregnant? [ ] Yes [ ] No Due Date? ____________________

Are you nursing? [ ] Yes [ ] No

Are you taking birth control? [ ] Yes [ ] No

Medications	Allergies		
List any medications you are currently taking, and why you take it:	For your health and safety, please mark any Known drug or material allergies:		
	___Aspirin	___Iodine	___Penicillin
	___Barbiturates	___Latex	___Sulfa
Pharmacy Name	___Codeine	___Local Anesthetics	
Pharmacy Phone Number	Other (list):		

Physician's Name______________________________ Date of Last Medical Visit ___________

Previous hospitalizations, serious illnesses, or operations: ____________________________

____

I understand that providing incorrect or incomplete information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in my medical status. To the best of my knowledge, I have provided EAST VALLEY DENTAL PROFESSIONALS with accurate and complete health and dental information. I authorize the dental staff to perform the necessary dental services I may need.

Patient or Guardian Signature Printed Name Date

Doctor or Hygienist Signature Printed Name Date

EAST VALLEY DENTAL PROFESSIONALS FINANCIAL POLICY

(Please read and initial at each line.)

We appreciate your selection of this office to serve your dental needs. Our interest is to provide our patients with the finest possible, quality dental care. We must attend to the financial aspects of dental treatment as well. Following is an overview of our office financial policy.

____ **Payment.** Payment in full is required at the time of service. For your convenience, we accept cash, debit, and credit cards, including Visa, Master Card, Discover, and American Express.

____ **Insurance.** Dental Insurance never pays for 100% of all dental services. As a courtesy, we will bill your dental insurance for your care, providing you give us the needed information for claim submission.

- ____At the time of service, we will request from you an initial payment, the estimated portion of the charges which insurance may not cover, including all applicable deductibles and co-pays.
- ____After your dental insurance settles your claim, any remaining balance is your responsibility.
- ____Payment from the insurance company is expected within thirty (30) days. If your insurance company has not responded within a sixty (60) days grace period from the date of service, the remaining balance in full is your responsibility.
- ____Questions and concerns with your dental coverage and the payment of your claim(s) are the sole responsibility of the insured, and should be resolved with the insured's employer and/or dental insurance company. Your coverage is a result of the contract between the insured's employer and the dental insurance company, and our office has no control over payment or non-payment of your claims.
- ____As your dental care provider, we advise treatment that is in the best interest of your medical and dental health. Insurance companies select the dental procedures that they will and will not cover without regard to your personal situation, health, and dental needs.
- ____It is the sole responsibility of you, the patient, to familiarize yourself with the rules, terms, exclusions, clauses, and benefit limitations of your dental insurance policy.

____ **Estimates.** Before treatment, we will perform a diagnosis and provide you with an estimate of the charges involved. As treatment progresses, it is possible that additional circumstances not apparent at the initial exam, may be encountered. In this event, we will discuss options with you and proceed upon your approval.

____ **Aged Account.** The total balance on your account, after claim settlement, is due immediately upon receipt of statement. Failure to keep this account current may result in EAST VALLEY DENTAL PROFESSIONALS being unable to provide additional dental services. In the event of a default, I agree that any information collected can be used to collect on my account. If my account goes to collection, I agree to pay a 35% collection fee.

____ **Copyright.** Any comment posted online in any way relating to EAST VALLEY DENTAL PROFESSIONALS or any Employee, will be the sole right and property of EAST VALLEY DENTAL PROFESSIONALS and the copyright of the content of the comment, rating, or review is hereby assigned to EAST VALLEY DENTAL PROFESSIONALS to utilize or delete at our discretion, and/or in order to protect the patient's anonymity and privacy.

____ **Appointments.** If unable to keep a scheduled appointment, we ask that you provide us with 48 hours notice as a courtesy. **Notice of less than 48 hours will result in a minimum charge of $50.00, the amount to vary depending on the magnitude of the failed appointment.**

____ **Assignment of Benefit.** I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my dental claims. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to EAST VALLEY DENTAL PROFESSIONALS.

I have read, understand, and agree to the above.

______________________________	______________________________	__________
Signature of Person Responsible for Account	**Printed Name of Person Responsible for Account**	**Date**

EAST VALLEY DENTAL PROFESSIONALS
2058 S DOBSON ROAD, SUITE 12
MESA, AZ 85202

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this Acknowledgement

I, ________________________________ have read a copy of this office's Notice of Privacy Practices.

____
Signature

____
Date

FOR OFFICE USE ONLY

- o Individual refused to sign
- o Communications barrier prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (Please Specify)

____
____
____