7-7 DENTAL
7102 N. 35th Ave., Ste #1
Phoenix, AZ 85051
(602) 242-1996
www.7-7dental.com

PERSONAL INFORMATION

Dr. Mr. Mrs. Ms. Miss Name _____

Preferred Name _____ Date of Birth _____ SS# _____

Home Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____

Employer _____ Business Phone _____

Address _____ City _____ Zip _____

What caused you to seek dental treatment at this time? _____

Emerg Contact _____ Relation to Patient _____ Phone _____

Person Responsible for Financial Arrangements _____

Previous Family Dentist _____ Phone _____

Address _____ City _____ Zip _____

MEDICAL HISTORY

Height _____ Weight _____

How would you describe your general health? Good Fair Poor

Date of last medical examination _____

Your Physician(s) _____

Have you had any serious illnesses or operations? (If so, please list) _____

Are you taking any medication at the present time? Yes No

Please List _____

Are you allergic to any medications? Yes No

Please List _____

Have you ever been treated for any of the following conditions?

	YES	NO		YES	NO		YES	NO
Heart Disease			Prosthetic Joint			Tumor or Cancer		
Stroke			Epilepsy/Seizures			Arthritis		
High/Low Blood Pressure			Asthma/Hay Fever/Allergies			Bleeding Disorder		
Heart Murmur/Valve Defect			Sinus Trouble			Anemia		
Herpes			Tuberculosis			Hepatitis (Jaundice)		
Depression			Diabetes			AIDS/HIV Positive		
Bruise Easily			Stroke			Jaw Pain		
Tobacco Habit			Artificial Joints			Chemotherapy		
Respiratory Disease			Chemical Dependency			Radiation Treatment		

Are you taking any type of blood thinner at the present time? Yes No

If yes, please list which one and for how long: _____

If yes, please list which one and for how long: _____

DENTAL HISTORY

	YES	NO
Do you have any dental pain at present?		
Have any of your previous dentists mentioned that you had "gum problems"?		
Have you consulted any other periodontist about periodontal problems?		
Does your "bite" feel off?		
Do you habitually clench your teeth during the day or night?		
Have you worn orthodontic appliances to straighten your teeth?		
Do you use a tobacco product?		
How often do you brush your teeth ? _____ Floss? _____		
When was the last time you had your teeth cleaned by your dentist/hygienist?		
Would loss of your teeth be of great concern to you?		

FOR WOMEN ONLY

Are you pregnant?		
Have you passed menopause?		
Are you taking birth control pills?		
Are you nursing?		

UPDATE

Signature _____ Date _____

FINANCIAL AGREEMENT

Payment is due the day of service. If you have insurance that we accept, your estimated deductible and/or co-payments are due at the time of service. Co-pay estimates are subject to final approval by your insurance company; therefore, the amount due in our office is subject to change. Teenage children who come in on their own will need to have their co-payment sent with them and it will be collected at the beginning of the appointment. For younger children, the parent accompanying the child will be responsible for paying the co-payment. Payment options are available and must be agreed on before any services are rendered.

I agree to be financially responsible for all procedures I elect to have performed. I understand and agree that all fees are required to be paid in full at time of service. I understand and agree that any unpaid balance over thirty (30) days will be charged an interest fee of 18% annually. I understand and agree that should my account require collection efforts, all court costs and attorney fees, plus a 50% collection fee will be added to my account.

Our office requires at least 24 hours notice to cancel or reschedule an appointment. A **$25 fee** will be charged to the guarantor's account for a missed appointment without sufficient notice or a same-day cancellation. A credit card number may be required to reserve another appointment. If the second appointment is cancelled without sufficient notice or is cancelled same-day, the guarantor's credit card will be charged **$50**. After two missed or cancelled appointments, the patient may not be seen again in any of our Apex offices. Your cooperation in this matter is appreciated.

CONSENT TO PROCEED

I authorize Dr. Dana Perno and/or such Associates or Assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic and/or other pharmaceutical agent (s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment, items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the Doctor any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

_____ I have received a copy, or have been offered and declined a copy, of this office's Notice of Privacy Practices.

Patient, Legal Guardian or Authorized Agent Signature: _____Date: _____

Doctor Signature: _____ Date: _____