# Advanced Laser Dentistry
## PATIENT REGISTRATION

ID: _____ ChartID: _____

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder ☐ Responsible Party

Preferred Name: _____

**Responsible Party (if someone other than the patient)**

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

**Patient Information**

Address: _____ Address 2: _____

City: _____ State, Zip _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

Physician Name _____

Physician Phone # _____

Legal Guardian Name _____

Legal Guardian Phone # _____

Ref. Source_____

**Primary Insurance Information**

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Ins. Company: _____

Address: _____

Address 2: _____

City, State, Zip: _____

**Secondary Insurance Information**

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Ins. Company: _____

Address: _____

Address 2: _____

City, State, Zip: _____

# Advanced Laser Dentistry
## PATIENT MEDICAL HISTORY

Patient Name: _____ Birth Date: _____ Date Created: _____

**Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems 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 _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯Yes ◯No _____
Are you on a special diet? ◯Yes ◯No
Do you use tobacco? ◯Yes ◯No

**Women: Are you**

Pregnant / Trying to get pregnant? ◯Yes ◯No Nursing? ◯Yes ◯No Taking oral contraceptives? ◯Yes ◯No

**Are you allergic of any of the following?**

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs

☐ Other If yes, please explain _____

Do you use controlled substances? ☐Yes ☒No If yes, _____

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

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive | ◯Yes ◯No | Cortisone Medicine | ◯Yes ◯No | Hemophilia | ◯Yes ◯No | Radiation Treatments | ◯Yes ◯No |
| Alzheimer's Disease | ◯Yes ◯No | Diabetes | ◯Yes ◯No | Hepatitis A | ◯Yes ◯No | Recent Weight Loss | ◯Yes ◯No |
| Anaphylaxis | ◯Yes ◯No | Drug Addiction | ◯Yes ◯No | Hepatitis B or C | ◯Yes ◯No | Renal Dialysis | ◯Yes ◯No |
| Anemia | ◯Yes ◯No | Easily Winded | ◯Yes ◯No | Herpes | ◯Yes ◯No | Rheumatic Fever | ◯Yes ◯No |
| Angina | ◯Yes ◯No | Emphysema | ◯Yes ◯No | High Blood Pressure | ◯Yes ◯No | Rheumatism | ◯Yes ◯No |
| Arthritis/Gout | ◯Yes ◯No | Epilepsy or Seizures | ◯Yes ◯No | High Cholesterol | ◯Yes ◯No | Scarlet Fever | ◯Yes ◯No |
| Artificial Heart Valve | ◯Yes ◯No | Excessive Bleeding | ◯Yes ◯No | Hives or Rash | ◯Yes ◯No | Shingles | ◯Yes ◯No |
| Artificial Joint | ◯Yes ◯No | Excessive Thirst | ◯Yes ◯No | Hypoglycemia | ◯Yes ◯No | Sickle Cell Disease | ◯Yes ◯No |
| Asthma | ◯Yes ◯No | Fainting Spells/Dizziness | ◯Yes ◯No | Irregular Heartbeat | ◯Yes ◯No | Sinus Trouble | ◯Yes ◯No |
| Blood Disease | ◯Yes ◯No | Frequent Cough | ◯Yes ◯No | Kidney Problems | ◯Yes ◯No | Spina Bifida | ◯Yes ◯No |
| Blood Transfusion | ◯Yes ◯No | Frequent Diarrhea | ◯Yes ◯No | Leukemia | ◯Yes ◯No | Stomach/Intestinal Disease | ◯Yes ◯No |
| Breathing Problem | ◯Yes ◯No | Frequent Headaches | ◯Yes ◯No | Liver Disease | ◯Yes ◯No | Stroke | ◯Yes ◯No |
| Bruise Easily | ◯Yes ◯No | Genital Herpes | ◯Yes ◯No | Blood Pressure | ◯Yes ◯No | Swelling of Limbs | ◯Yes ◯No |
| Cancer | ◯Yes ◯No | Glaucoma | ◯Yes ◯No | Lung Disease | ◯Yes ◯No | Thyroid Disease | ◯Yes ◯No |
| Chemotherapy | ◯Yes ◯No | Hay Feve | ◯Yes ◯No | Mitral Valve Prolapse | ◯Yes ◯No | Tonsillitis | ◯Yes ◯No |
| Chest Pains | ◯Yes ◯No | Heart Attack/Failure | ◯Yes ◯No | Osteoporosis | ◯Yes ◯No | Tuberculosis | ◯Yes ◯No |
| Cold Sores/Fever Blisters | ◯Yes ◯No | Heart Murmur | ◯Yes ◯No | Pain in Jaw Joints | ◯Yes ◯No | Tumors or Growths | ◯Yes ◯No |
| Congenital Heart Disorder | ◯Yes ◯No | Heart Pacemaker | ◯Yes ◯No | Parathyroid Disease | ◯Yes ◯No | Ulcers | ◯Yes ◯No |
| Convulsions | ◯Yes ◯No | Heart Trouble/Disease | ◯Yes ◯No | Psychiatric Care | ◯Yes ◯No | Venereal Disease | ◯Yes ◯No |
| | | | | | | Yellow Jaundice | ◯Yes ◯No |

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

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** _____

# Advanced Laser Dentistry
## PRACTICE POLICIES

### Payment Policy

I agree to pay for all services rendered on the date of service.
I understand that I am financially responsible for charges not paid by my insurance **including but not limited to**: downgrade of resin based fillings, crowns, bridges, and dentures.

### Cancellation Policy

Please keep in mind that your appointment is important to us.
If for any reason you need to cancel or reschedule your appointment please notify Advanced Laser Dentistry at least 48-hours prior to your appointment. **Failure to notify prior to your schedule appointment will result in a $75.00 service charge and the right for Advanced Laser Dentistry to terminate the service.** Again, please be considerate and notify in advance, this way the time slotted for your scheduled appointment can be made available to other patients

_____
Initials

_____
Signature

* If you would like a copy please ask the front desk.


**Office Location**

| | | |
|---|---|---|
| Surprise | 16952 W. Bell Rd Suite 301, Surprise AZ 85374 | Phone (623)474-4841 |
| Phoenix | 6819 N. 16th St Suite 4, Phoenix AZ 85016 | Phone (602)840-5100 |

**www.AZLASERDENTISTRY.com**
email: advancedlaserdentistry@yahoo.com