Marcia L. Blazer, D.D.S., P.C.

Phone: 480.596.8273

Today's Date ___________________

Patient Information

Patient Name ________________________ Marital Status ____________ Date of Birth ______________

Home Phone ____________________ Work ____________________ Cell ____________________

Patient Address ________________________ City ____________ State ______ Zip __________

Employer Name ________________________ Patient Social Security # ____________________

Emergency Contact Name and Phone # ________________________ Occupation ________________

Email ____________________ How did you hear about our office? ________________________

Responsible Party Information (if different from above)

Name ________________________ Marital Status ____________ Date of Birth ______________

Home Phone ____________________ Work ____________________ Cell ____________________

Address ________________________ City ____________ State ______ Zip __________

Employer Name ____________________ Social Security # ______________ Email ______________

Insurance Information: Full Name of Insurance Company ____________________

Insured Person ________________________ Insured's Date of Birth ____________________

Insured's Employer ________________________ Insured's Social Security # ________________

Group Number ____

Medical History

Have you ever, or do you have, any of the following? Please check Yes or No for each item and provide the date of occurrence or diagnosis.

	YES	NO	DATE		YES	NO	DATE		YES	NO	DATE
Acid Reflux/GERD	❑	❑		Chest Pain/Angina	❑	❑		Hepatitis (A, B or C?)	❑	❑	
AIDS/HIV	❑	❑		Depression	❑	❑		Herpes/Shingles	❑	❑	
Anemia	❑	❑		Diabetes (Type 1 or Type 2)	❑	❑		High Blood Pressure	❑	❑	
Anxiety	❑	❑		Emphysema/COPD	❑	❑		Kidney disease	❑	❑	
Artificial Heart Valve	❑	❑		Epilepsy/Seizures	❑	❑		Liver disease	❑	❑	
Artificial Joint	❑	❑		Fainting/Dizziness	❑	❑		Low Blood Pressure	❑	❑	
Asthma	❑	❑		Fibromyalgia	❑	❑		Schizophrenia	❑	❑	
Bipolar	❑	❑		Heart attack	❑	❑		Sinus problems	❑	❑	
Bleed or Bruise easily?	❑	❑		Heart murmur/MVP	❑	❑		Sleep apnea or CPAP	❑	❑	
Cancer/Radiation/Chemo	❑	❑		Heart surgery	❑	❑		Stroke	❑	❑	
								Thyroid disease	❑	❑	

Please elaborate on any "Yes" responses:

Are you allergic to, or have you ever had a reaction to: (please check Yes or No for each one)

	YES	NO		YES	NO		YES	NO
Local anesthetic (numbing medication)	❑	❑	Penicillin	❑	❑	Latex	❑	❑
Codeine or other narcotic medication	❑	❑	Aspirin	❑	❑	Sulfite Preservative	❑	❑
Antibiotic	❑	❑	Other	❑	❑	Any Dental Materials	❑	❑

Please list ALL medications you are currently taking (including supplements and over-the-counter medications)

Are you on dialysis? YES ❑ NO ❑

If you are female, are you pregnant? YES ❑ NO ❑

Nursing? YES ❑ NO ❑ Taking birth control pills? YES ❑ NO ❑

Please list any medical procedures/surgery in the last 2 years:

Do you have any disease, condition or problem that is not listed above?

Do you typically premedicate with antibiotic before dental appointments? YES ❑ NO ❑

Do you have a history of drug or alcohol abuse? YES ❑ NO ❑

How can we help you today?

Dental History

When was your last dental visit? For what reason?

Are you having any problems with your mouth or teeth today? Please describe.

	YES	NO
Do your gums bleed while brushing or flossing?	❑	❑
Are your teeth sensitive to brushing, hot, cold, sweets or sour foods/liquids?	❑	❑
Have you noticed any loosening of your teeth?	❑	❑
Have you noticed bad breath?	❑	❑
Have you ever experienced any of the following problems in your jaw?		
a. Clicking?	❑	❑
b. Pain (joint, ear, side of face)?	❑	❑
c. Difficulty in chewing?	❑	❑
d. Difficulty opening or closing?	❑	❑
Do you smoke?	❑	❑
How much?		
Do you use chewing tobacco?	❑	❑
Have you had any head, neck or jaw injuries?	❑	❑
Do you have frequent headaches?	❑	❑

	YES	NO
Do you clench or grind your teeth while awake or asleep?	❑	❑
Have you ever had:		
a. Orthodontic treatment (braces)?	❑	❑
b. Oral surgery?	❑	❑
c. Gum treatments?	❑	❑
d. Your teeth ground or the bite adjusted?	❑	❑
e. Worn a bite plate or other appliance?	❑	❑
Are you satisfied with the appearance of your teeth?	❑	❑
Would you like more information about our cosmetic dental options ?	❑	❑
Have you had any trouble with previous dental treatment?	❑	❑
Are you anxious about having dental treatment?	❑	❑

Please elaborate on any of the above responses:

I certify that I have read and understand the above questionnaire and all questions have been answered to the best of my knowledge. I will not hold the dentist or office staff responsible for any omissions that I may have made in completion of this form.

Signature of Patient or Responsible Party / Date

Marcia L Blazer DDS, PC
Family & Cosmetic Dentistry

Phone: 480.596.8273

About our fees

We are committed to providing you with the best possible care. If you have dental insurance, we will help you determine the coverage available. We will file your insurance claims as a courtesy, provided that we are able to verify your coverage prior to your appointment. Please understand, however, your insurance is a contract between you, your employer and your insurance company. We are not a part of that contract. **While we may accept partial payment from your insurance company, all charges are ultimately your responsibility.** You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs, and expenses, including reasonable attorney fees, we incur in such collection efforts.

Payment is due at the time services are rendered. Our payment options are cash, personal check, Mastercard, Visa, Discover and CareCredit (Carecredit.com)**. Please ask about our extended payment plan options with CareCredit, our senior citizen courtesy for patients 65 and over, and our cash courtesy.**

Signature of Patient or Legal Guardian____ **Date** ____________

Consent for Use and Disclosure of Health Information

Purpose of Consent: By signing this form, you are consenting to our use and disclosure of your protected health information as necessary.

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 options, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. The full and complete notice is available for your viewing.

We reserve the right to change our privacy practices and will have available a revised notice. You have the right to revoke this consent at any time by giving us a written notice. Please understand that we may decline to treat you if you revoke this consent.

I understand that this consent form allows Dr. Blazer's office to share relevant personal health information with other health care providers and insurance companies. I understand that I may revoke this consent at any time.

Signature of Patient or Legal Guardian____ **Date** ____________

Patients with Insurance

If you have dental insurance, we will help you determine the coverage available and how to receive optimum benefits from your plan to the best of our ability.

Our office relies on you to let us know if your insurance has changed. We try to keep abreast of all insurance benefits, but it is ultimately up to you to know your insurance coverage.

We are happy to do a pre-determination of benefits upon your request.

Payment for your portion is due at the time of services rendered. We try to keep our office costs to a minimum by not balance billing.

Signature of Patient or Legal Guardian____ **Date** ____________

We look forward to caring for your dental needs and encourage you to communicate your questions and concerns with us. Our relationship with you is important to us and we value you as a patient!