Date

ADULT INFORMATION SHEET

Patient Name		Social Security Number	Birthdate / /
Home Address		City, State, Zip	Home Phone ( )
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed	Gender ❑ M ❑ F	Email	Cell Phone ( )
Employer _____			Employer's Phone ( )
Employer's Address _____			ID #
Primary Dental Insurance _____			ID #
Secondary Dental Insurance _____			

Spouse's Name	Cell Phone ( )	Social Security Number	Birthdate / /
Spouse's Employer Spouse's Employer's Phone			( )
Spouse's Employer's Address	City	State	Zip

If the insurance policyholder is not the patient, please complete the following:

Insured's Name	Social Security Number	Birthdate / /
Relationship to the patient:		
Insured's Home Address	City, State, Zip	Home Phone ( )
Insured's Employer	Insured's Employer's Phone ( )	
Insured's Employer's Address	City	State Zip

How were you referred to our office?_____

CONSENT

*I will answer all health questions to the best of my knowledge. _____
(Initial)

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgement of the doctor may dictate in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

_____ _____ _____

*Signature Date Relationship to Patient

AGREEMENT TO PAY

I agree to pay my estimated portion for all services rendered at the time of service. In the event that payment is not made within thirty (30) days of receipt of statement, a service charge at the legal rate may be added to the past due balance. If a collection agency services are required, I further agree to pay for all legal fees and costs incurred in connection therewith. Service charges not paid when due shall be added to and become part of the principal and bear like interest until paid. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security number or any other information I have given you. I understand that any and all fees incurred for dental treatment are my total and ultimate responsibility, regardless of any insurance I may have. In the event that my insurance does not provide benefits or provides a reduced benefit, I will be financially responsible to pay for the services rendered. I understand that this office requires payment in full for all services provided within (90) days of treatment. If payment has not been made by my insurance company within (90) days, I am aware that I will be responsible for paying the balance in full within that same time frame. I am also aware that a $30 fee will be assessed for any and all returned checks. Furthermore, I am aware that there may be a $25 fee for each 1/2 hour of any missed appointments or appointments not cancelled 24 hours before the scheduled time.

_____ _____

*Signature Date

PATIENT'S DENTAL HEALTH

Why have you come to see us today? (e.g.: pain, checkup, etc.) _____

Previous Dentist _____ Last Visit _____ Date of Last Cleaning _____

_____

Have you had any problems with past dental treatment? _____

Are you nervous about seeing a dentist? ❑ Yes! ❑ No If yes, please tell us why: _____

How often do you brush? _____ Do you floss? ❑ Yes ❑ No How often? _____

(Please circle each)

Y N I clench or grind my teeth during the day or while sleeping.
Y N My gums bleed while brushing or flossing.
Y N I like my smile.
Y N I prefer tooth-colored fillings.
Y N I avoid brushing part of my mouth due to pain.
Y N My gums feel tender or swollen.
Y N I have problems eating.
Y N I have had orthodontics.
Y N I have had a facial or jaw injury.
Y N I want my teeth straighter.
Y N I want my teeth whiter.

What are your dental priorities? _____
(e.g.: appearance, dental health, financial considerations, etc.)

I consider my health to be *(Please check one)*: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Do you have or have you had any of the following? *Please circle Y for yes or N for no.*

1. Y N Heart Disease
2. Y N Heart Murmur/Mitral Valve Prolapse
3. Y N Stroke
4. Y N Congenital Heart Lesions
5. Y N Rheumatic Fever
6. Y N Abnormal Blood Pressure
7. Y N Anemia
8. Y N Prolonged Bleeding Disorder
9. Y N Tuberculosis or Lung Disease
10. Y N Asthma
11. Y N Hay Fever
12. Y N Sinus Trouble
13. Y N Epilepsy/Seizures
14. Y N Ulcers
15. Y N Implants/Artificial Joints: Hip-Knee _____ Other _____
16. Y N I smoke or use chewing tobacco. If yes, how much per day? How many years?
17. Y N I have consumed alcohol within the last 24 hours.
18. Y N I usually take an antibiotic prior to dental treatment.
19. Y N Have you ever taken Fen-Phen or Redux?
20. Y N I have had major surgery. Year _____ Type of operation _____ Year _____ Type of operation _____
21. Y N Do you have any other medical problem or medical history NOT listed on this form?
22. Y N Liver Disease
23. Y N Jaundice
24. Y N Hepatitis Type _____
25. Y N Diabetes
26. Y N Excessive Urination and/or Thirst
27. Y N Infectious Mononucleosis ("Mono")
28. Y N Herpes
29. Y N Arthritis
30. Y N Sexually Transmitted/Venereal Diseases
31. Y N Kidney Disease
32. Y N Tumor or Malignancy
33. Y N Cancer/Chemotherapy
34. Y N Radiation/Therapy
35. Y N History of Drug Addiction
36. Y N AIDS
37. Y N Immune Suppressed Disorder
38. Y N Hearing Loss
39. Y N Fainting Spells
40. Y N Glaucoma
41. Y N History of Emotional or Nervous Disorders

WOMEN:

42. Y N Are you taking birth control medication?
43. Y N Are you or could you be pregnant or nursing?

Doctor Notes Only:

Are you allergic to any of the following?
Please circle Y for yes or N for no

44. Y N Aspirin/Ibuprofen
45. Y N Sulfa Drugs/Sulfites/Sulfides
46. Y N Penicillin
47. Y N Codeine
48. Y N Latex, Metals, Plastics
49. Y N Local Anesthetics (Novocaine)
50. Y N Other Medications. Which ones? _____

_____

Please list all medications you are currently taking:

_____

_____

_____

_____

Physician's Name _____ Phone _____

Address _____ Fax _____

In the event of an emergency, please contact:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

X _____ / / X _____ / /
Patient's Signature Date Patient's Signature Date

Medical health reviewed by:

_____ / / _____ / /
Doctor's Signature Date Doctor's Signature Date

_____ / / _____ / /
Doctor's Signature Date Doctor's Signature Date

Date:_____

ZUCH PERIODONTICS AND DENTAL IMPLANTS
JASON ZUCH, DDS, MS, PLLC
5533 E. Bell Rd, Suite 115-B
Scottsdale, AZ 85254

PERMISSION FOR CONFIDENTIAL COMMUNICATION

We will attempt to contact you in person to discuss your health and treatment. However we may often have to communicate with our patients through voice mail and leaving messages. To ensure your privacy, please provide us with a phone number that has an answering machine, or voice mail, so that we can reliably leave a phone communication for you.

I, _____, agree to furnish the phone number below to Dr. Jason Zuch and his staff for the purpose of communicating with me. I understand that this phone number will be used to leave messages that may contain private information such as appointment confirmations, clinical information, medications, surgical or follow up instructions, as well as financial or insurance information. I will be responsible to inform Dr. Zuch or a staff member whenever I want to change this contact number.

Also, can you identify a person, with whom we may leave messages about procedures or test results if we cannot reach you? Or do you allow someone to call us to ask questions about treatment on your behalf? Please circle YES NO.

If YES, please list their name_____, and their relationship to you_____, and their phone number_____.

You may also list additional names if you desire:
Name_____
Relation_____
Phone_____

Patient is responsible to update these numbers if they change.

Phone _____

Signed patient_____ Date_____

Date:_____

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JASON ZUCH, DDS, MS, PLLC
5533 E. Bell Rd. Suite 115-B
Scottsdale, AZ 85254

FINANCIAL POLICY

I understand that the responsibility for payment for the dental services that are provided in this office for myself or my dependents in mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1.5% finance charge (18% APR) may be added to my account.

I understand that my insurance coverage is a contract between the insurance company and my employer. Not all services are covered benefits. Some insurance companies arbitrarily select certain procedures they will not cover. We must emphasize that as a dental care provider, our relationship is with you, and not your insurance company. Filing your insurance claim is a courtesy we extend to all our patients.

I understand your office can make no guarantee of any estimated coverage or payment by my insurance company. I the event my insurance does not pay within 45 days from the date claim is submitted by Zuch Periodontics or Jason Zuch, DDS, MS, PLLC, I will be responsible for the total obligation.

I hereby instruct and direct my insurance company to pay direct payment to Zuch Periodontics or Jason Zuch, DDS, MS, PLLC for services rendered by this office. I authorize Zuch Periodontics or Jason Zuch, DDS, MS, PLLC to initiate a complaint to the Insurance Commissioner for any reason mon my behalf.

I understand Zuch Periodontics or Jason Zuch, DDS, MS, PLLC offers many forms of payment. All major credit cards are accepted.

I understand that in the event that my account would need to be assigned to an outside collection agency, a 30% collection fee of the balance will be added to the account prior to assignment.

I understand that if I elect not to provide my social security number, I will provide a copy of my Arizona driver's license and/or a legal form or photo ID.

I understand that my appointment time has been especially reserved for me, and in the event that I need to reschedule, I will give a 24 business hour notice. Failure to do so will result in the cancellation fee.

I understand that it is my responsibility to advise this office of any changes in the information I provide regarding my insurance, patient information, or the health history form.

I understand that fees are applicable for dental records, and/or copies of dental X-rays. I understand that there will be a $25.00 non-sufficient funds fee added to my account in the event of a returned check.

Patient signature_____ Date_____
Parent or responsible party_____ Relationship_____

NOTICE OF PRIVACY PRACTICES

Patient Acknowledgment of Receipt

[Patient May Refuse To Sign this Agreement]

DR. JASON ZUCH

(name of healthcare practice or doctor's name)

This Healthcare Practice recognizes that every patient has the Right of Privacy concerning their personal health information. We make every effort to protect and preserve patient records in a manner that secures this information.

By signing this Acknowledgement:
You are only confirming that you have READ a copy of our PRIVACY PRACTICES.

You do not give up any of your Rights and you may choose at some point in the future to provide more specific instructions for us to follow regarding your personal health information.

I have received a copy of this office's Notice of Privacy Practices:

Print your name here: _____

Sign your name here: _____

Fill in today's date here: _____