SCOTTSDALE
Family & Cosmetic Dentistry

KENT P. SABA, D.D.S.
CHRISTOPHER W. FOWLER, D.D.S.

Today's Date_____

GENERAL INFORMATION

Patient Name _____ Age _____

If child, Parents name _____

Home address_____ Home Phone _____

City _____ State _____ Zip code _____

Date of birth _____ Social Security# _____

Patient/Parent employed by _____

Business address_____ Business Phone _____

City_____ State _____ Zip code _____

Referred by _____ ❑ Website ❑ Insurance ❑ Yellow Pages

Name/ Address/Phone# of nearest friend/relative _____

MEDICAL HISTORY

Physician's Name_____ Phone_____

Are you in good health? _____ If no explain _____

Have you been hospitalized in the past two years? _____

Do you bleed excessively when cut _____Do you smoke?_____Do you use smokeless tobacco?_____

If you are currently taking any medications, supplements, or vitamins please list_____

_____

Osteoporosis Medications ❑ Yes ❑ No What Type?: _____

History of Osteoporosis Medications ❑ Yes ❑ No What Type?: _____

Please check any of the following that may apply:

Yes	No		Yes	No	
❑	❑	1. Cancer Type:_____Date:_____	❑	❑	14. Ulcers
❑	❑	2. Glaucoma	❑	❑	15. Mitral Valve Prolapse
❑	❑	3. Heart Disease If you have a cardiac condition what type /what are your symptoms? _____	❑	❑	16. Radiation/Chemo Treatment Date:_____
			❑	❑	17. Liver Disease
			❑	❑	18. Kidney Disease
			❑	❑	19. Hepatitis A B or C
❑	❑	4. High Blood Pressure: What is normal? _____	❑	❑	20. A.I.D.S/HIV:status_____
			❑	❑	21.Asthma:which type? _____
❑	❑	5. Blood Disease or Bleeding Tendency	❑	❑	22. Tuberculosis
❑	❑	6. Rheumatic Fever	❑	❑	23. Allergy to: Penicillin
❑	❑	7. Heart Murmur	❑	❑	24. Allergy to:Other Antibiotics_____
❑	❑	8. Diabetes	❑	❑	25. Allergy to: Local Anesthetics_____
❑	❑	9. Stroke	❑	❑	26. Allergy to:Other_____
❑	❑	10. Epilepsy /Nervous Disorder	❑	❑	27. Are you pregnant
❑	❑	11. Arthritis	❑	❑	28. Sinus Trouble
❑	❑	12. Tumor History	❑	❑	29. Neck or Back Trouble
❑	❑	13. Joint, Hip/Knee Replacement Date:_____	❑	❑	30. Latex Allergy
			❑	❑	31. Pace Maker

DENTAL HISTORY

Reason for visit _____

Previous dentist _____ Date last treated _____

Date of last cleaning _____ Date of last x-rays _____

What is your daily hygiene regimen _____

Circle any of the following that may apply:

1. Bleeding gums
2. Clenching/Grinding your teeth
3. Sensitivity to: Heat, cold or pressure
4. Difficulty opening
5. Pain in the joint/jaw/ear/side of face
6. Bad mouth odor/tastes
7. Loose teeth
8. Dry Mouth
9. Headaches, neck aches, shoulder aches

Do you like the appearance of your teeth, your smile? _____

What would you like to change the most in the appearance of your teeth? _____

_____

CONSENT FOR TREATMENT

I hereby grant complete authority to Dr. Kent P. Saba / Dr. Chris Fowler to administer such x-rays, anesthetics, and to perform such procedures as may be deemed necessary or advisable in the diagnosis and treatment of my dental condition.
I understand I am financially responsible to pay for all services done.

Signature _____ Date _____

Signature of parent if minor.

INSURANCE INFORMATION

Name of Policyholder _____ Group # _____

Primary Insurance Company Name _____

Address _____

City _____ State _____ Zip code _____

Name of Policyholder _____ Group # _____

Primary Insurance Company Name _____

Address _____

City _____ State _____ Zip code _____

ASSIGNMENT OF BENEFITS

I authorize my insurance company to make payment directly to: Kent P. Saba, D.D.S. or Chris Fowler, D.D.S.

Signature _____ Date _____

Signature of policy holder.