Mountain View Dentistry of Globe
PATIENT INFORMATION

Patient Name:_____Age_____Home Phone:(_____) _____-_____
Mailing Address:_____Work Phone:(_____) _____-_____
CITY_____ STATE_____ ZIP_____Mobile Phone:(_____) _____-_____ (OK TO TEXT) ☐
Physical Address:_____ Same as Above ☐
CITY_____ STATE_____ ZIP_____
Sex:_____Marital Status:_____ Birthday:___ /____/_____Social Security #: _____
Patient E-mail address:_____Preferred Method of Contact:_____
Employer:_____Occupation:_____
How long employed:_____Employer (H/R) Phone: (_____) _____-_____
Employer Address: STREET_____
CITY_____ STATE_____ ZIP_____

Emergency Contact:_____Relationship:_____ Primary Phone #(_____) _____-_____
Address:_____ Secondary Phone #(_____) _____-_____

RESPONSIBLE PARTY INFORMATION:
Relationship to patient: ( ) Self ( ) Parent ( ) Spouse ( ) Other_____
Name:_____ Age _____
Address (if different from above):
STREET_____
CITY_____ STATE_____ ZIP_____

Social Security Number_____
Employer_____
Employer's Address (if different from above):_____
How long Employed:_____ Employer (H/R) Phone: (_____) _____-_____
Occupation:_____

DENTAL INSURANCE INFORMATION
Dental Insurance Co:_____Insurance Phone # : (_____) _____-_____
Policyholder Name:_____ Employer Name: _____ Group #:_____
Policyholder Relationship to patient:_____
Policyholder Date of Birth:_____ / _____ _____ Policy Holder Social Security Number / ID:_____

Secondary Insurance Co:_____Employer Name:_____
Employer Address:_____ Employer (H/R) Phone #: (_____) _____-_____
Policyholder Name:_____ Relationship to patient:_____
Policyholder Date of Birth: _____ / _____ / _____ Group #:_____ Social Security # / ID: _____

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MEDICAL HISTORY

PATIENT NAME_____ DATE_____

Are you currently under the care of a physician? If so, why?_____

Physician's name(s)_____

Preferred Pharmacy_____

Have you ever had any serious injury to your head or neck?If so, what?_____

What medication, pills, or supplements are you taking now?_____

_____

WOMEN: (please check) ( ) Pregnant/trying to get pregnant ( ) Nursing ( ) Taking Oral Contraceptives* ( ) None of these

*by signing below, you acknowledge that if you are taking birth control pills, you are aware that antibiotics, such as penicillin or erythromycin, could possibly counteract the effects of the pill and render it ineffective against preventing pregnancy.

DOES YOUR MEDICAL HISTORY INCLUDE ANY OF THE FOLLOWING CONDITIONS? -CHECK ALL THAT APPLY

- ❑ Allergy- Check all that apply-( ) Aspirin ( ) Penicillin ( ) Codeine ( ) Latex ( ) Other_____
- ❑ HIV/AIDS – Circle one
- ❑ Hepatitis A / B / C (circle all that apply)
- ❑ Joint replacement (hip, knee, shoulder) When?_____
- ❑ Heart bypass surgery When?_____
- ❑ Pacemaker
- ❑ Artificial heart valve
- ❑ Mitral Valve Prolapse/ Heart Murmur
- ❑ Rheumatic Fever
- ❑ Stroke
- ❑ High / low blood pressure (circle one)
- ❑ Blood thinner (Plavix, Coumadin, Warfarin, Aspirin, Eliquis)
- ❑ Take medications for Osteoporosis (Fosomax or Boniva)
- ❑ Anemia
- ❑ Tuberculosis
- ❑ Ulcers or colitis
- ❑ Epilepsy
- ❑ Kidney problems
- ❑ Diabetes
- ❑ Arthritis
- ❑ Radiation treatment for cancer
- ❑ Malignancies or cancers What type?_____
- ❑ Nervous disorders, fainting, dizziness
- ❑ Venereal disease
- ❑ Asthma
- ❑ Fever blisters
- ❑ Drug / alcohol addiction (circle)
- ❑ Hay fever
- ❑ Sinus problems
- ❑ Smoking tobacco / marijuana (circle)
- ❑ Teeth sensitive to cold, heat, sweets, or pressure (circle)
- ❑ Clenching or grinding teeth
- ❑ Gums bleed easily
- ❑ Past periodontal treatment When?_____
- ❑ Special Needs/Cognitive Impairment
- ❑ GERD or digestive/stomach disorder_____
- ❑ Other Autoimmune Disorders_____

What is your chief dental concern?_____

When was your last dental exam?_____

How did you find us? ( ) Friend_____ ( ) Website ( ) Facebook ( ) Insurance Company ( ) Internet search ( ) Other_____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I will inform the dentist and staff at the next appointment without fail.

Patient signature_____ Date_____
(SIGNATURE OF PERSON AUTHORIZED TO CONSENT IF PATIENT IS UNDER 18 YEARS OF AGE)

To be filled out by Doctor or Hygienist ONLY	Updated: Date	Initial
Medical / Dental History Review:	_____	_____
	_____	_____
	_____	_____
	_____	_____

Doctor's Signature_____ Date_____

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MOUNTAIN VIEW DENTISTRY OF GLOBE

JAMES P. SMITH D.M.D.
MARSHALL J. GRIGGS D.D.S.

P.O. BOX 1243
GLOBE, ARIZONA 85502
(928) 425-3162

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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You May Refuse to Sign This ACKNOWLEDGEMENT

I, _____, have received a copy of this office's Notice of Privacy Practices.
Please Print Name

_____
Signature Date

I authorize **Mountain View Dentistry of Globe** to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist. I understand that my dental carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I certify that I or my legal guardian have had an opportunity to read and fully understand the terms and explanations of the procedure/s.

_____
Patient's (or Legal Guardian's) Signature Date

_____
Practitioner's Signature Date

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For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)_____

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Mountain View Dentistry

FINANCIAL POLICY

ASSIGNMENT AND RELEASE: I hereby authorize payment to **Mountain View Dentistry** for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges ,whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the use of this signature on all insurance submissions. I further authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason, on my behalf, should the need arise. _____ (Please Initial)

If there is insurance, the balance is due within 60 days from the date of service or when insurance pays, whichever is first. Pursuant to the Federal Consumer Credit Protection Act, we disclose that no interest charge will be applied if this agreement is adhered to. If the terms of this agreement are not met, interest charges of 1.5% per month is to be adhered to the remaining balance (18% per year) in addition to the entire balance becoming due. I also understand that upon failure to pay for the services rendered, my account (including all personal information) may be sent to a collection agency. _____ (Please Initial)

I understand that I am financially responsible for any item that is delivered to Mountain View Dentistry (ie crowns, dentures, bleach trays, nightguards, space maintainer, etc.). I understand that If I miss an appointment to pick up such items, that I am responsible for setting up another appointment to pickup (or cement) the item. If I fail to pick up such items delivered to Mountain View Dentistry, I understand that I am financially responsible for the entire cost of these items, as the insurance cannot be billed for undelivered items. _____ (Please Initial)

_____ _____

Patient Signature (OR parent/guardian if patient is a minor) Date

POST OPERATIVE INSTRUCTIONS

BLEEDING – Your bleeding should essentially be stopped by the time you get home. After you get home and take out the gauze, it is usually not necessary to place more gauze in your mouth unless there is still bright red blood running out of the extraction site, or if you are spitting out blood clots. To have blood present when you spit, or to have your saliva look bright pink is normal for the first day following extraction. If you do require the placement of more gauze, be sure it is directly over where the tooth or teeth were and be sure you bite with considerable force (it will probably be a little sore if you are biting hard enough). Leave this second gauze in for 30 minutes.

INFECTION – The best way to prevent infection is to keep your mouth clean. This should be done by brushing your teeth in your usual manner after each time you eat. Be gentle when brushing around the extraction site.

PAIN – Pain may be the most severe the first day, and then diminish each day thereafter. Pain that goes away after two or three days and then comes back is not normal. It is usually a sign of a "dry socket", which is a treatable problem. Please notify us immediately.

SWELLING – Swelling, if it occurs, is usually the result of the surgical procedure, and not fro infection. This is true if the swelling is present the day following surgery. This swelling should begin to go away about the third day following the procedure. If you have no swelling for 2-3 days and then suddenly swell up, or if your swelling is still present 5-6 days following surgery, this may represent the development of an infection. Please notify us.

EATING – On the day of the procedure, keep your diet soft. Starting the day after, eat as well as you can, even if it means relying entirely on liquids. A well balanced diet is essential to rapid healing. Some instances may require specific diet instructions. Please follow any specific instructions you were given by the doctor.

MEDICATIONS – If medications have been prescribed to you, take them as directed on the label. Most medications are best taken with food in the stomach unless specifically told not to do so on the label instructions. Pain medications, especially, should not be taken on an empty stomach. You should not drink alcohol, drive a motor vehicle or work around machinery when taking pain medications.

DO's – You may use an ice bag to reduce discomfort, swelling and possible bleeding the first twelve hours following the procedure. Do not leave it against the skin for more than 15 minutes at a time. You may rinse and soak the area with mouthfuls of warm salt water each hour for 4-5 minutes. Do not start these rinses until the day following the procedure.

DO NOT's – Avoid vigorous rinsing, sucking on the wound, frequent spitting, smoking and exercising until all bleeding has stopped. Do not drink alcohol (including mouthrinses) or soda pop for 1 day following the procedure as they may disrupt the blood clot.

NOTE – Expect moderate discomfort (even with pain medication), some swelling and some minor oozing of blood for the first 24 hours. However, if severe pain, swelling, or bleeding occurs, please notify us. If unable to contact our office, report to the hospital emergency department.

Mountain View Dentistry
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