Welcome

John H. Upton, Jr., DDS, MAGD
Castle Rock Plaza, Suite 201
6446 Highway 179, Sedona, Arizona 86351

Village Dentistry
(928) 284-9632

About You

Today's Date: _____ E-mail Address: _____

Name: _____ I prefer to be called: _____ ❑ Male ❑ Female
Last First Mi Mr Mrs Ms Dr

Birthdate: ___/___/___ Age: _____ Social Security #: _____ ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Address: _____
Street City State Zip

Home Phone #: (_____)_____ Cell/other #: (_____)_____ Work Phone #: (_____)_____ Ext: _____

Where & when are best times to reach you? _____ Whom may we thank for referring you? _____

Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street/PO Box City State Zip

Neighbor or Relative not living with you

His / Her Name: _____ Relation: _____ Work Phone #: (____)_____ Home Phone #: (____)_____

Address: _____
Street City State Zip

Spouse Information

His / Her Name: _____ Birthdate: ___/___/___ Social Security #: _____

Employer: _____ Work Phone #: (_____)_____ Ext: _____

Insurance Information

Primary Insurance Dental Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No Medical Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (____)_____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

Secondary Insurance Dental Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No Medical Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (____)_____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

CONTINUED ON BACK

Dental History

Why have you come to the dentist today? _____

_____

Are you currently in pain? ❑ Yes ❑ No

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Your current dental health is ❑ Good ❑ Fair ❑ Poor

Do you floss daily? ❑ Yes ❑ No Brush daily? ❑ Yes ❑ No

Type of bristles on your toothbrush? ❑ Hard ❑ Medium ❑ Soft

Do your gums ever bleed? ❑ Yes ❑ No Ever Itch? ❑ Yes ❑ No

Have you ever had periodontal disease? ❑ Yes ❑ No

Are your teeth sensitive to heat, cold, or anything else? _____

Do you have mobility in your teeth? ❑ Yes ❑ No

Do you still have wisdom teeth? ❑ Yes ❑ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Previous / Present Dentist: _____ Last Visit Date: _____
(Please Circle)

Would you like fresher breath? ❑ Yes ❑ No Whiter teeth? ❑ Yes ❑ No

Are you happy with the way your smile looks? ❑ Yes ❑ No

If not, what would you change? _____

_____

Medical History

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: _____

Address: _____
Street

_____
City State Zip

Phone #: (___)_____ Date of last visit: _____

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: _____

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Do you snore? ❑ Yes ❑ No

Do you have difficulty falling or staying asleep? ❑ Yes ❑ No

When you awaken in the morning, do you feel rested? ❑ Yes ❑ No

Are you tired/sleepy during the day? ❑ Yes ❑ No

Have you ever taken Fosamax or any other Bisphosphonate? ❑ Yes ❑ No

For Women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Unsure ❑ Yes ❑ No

Week #: _____ Are you nursing? ❑ Yes ❑ No

Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Colitis	Y N Hay Fever	Y N Liver Disease	Y N Seizures
Y N Alcohol Abuse	Y N Congenital Heart Defect	Y N Headaches	Y N Low Blood Pressure	Y N Shingles
Y N Anemia	Y N Diabetes	Y N Heart Attack	Y N Lupus	Y N Sickle Cell Disease
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Murmur	Y N Mitral Valve Prolapse	Y N Sinus Problems
Y N Artificial Bones/Joints	Y N Drug Abuse	Y N Heart Surgery	Y N Osteoporosis	Y N Steroid Therapy
Y N Artificial Valves	Y N Emphysema	Y N Hemophilia	Y N Pacemaker	Y N Stroke
Y N Asthma	Y N Epilepsy	Y N Hepatitis	Y N Persistent Cough	Y N Thyroid Problems
Y N Blood Transfusion	Y N Ever Hospitalized	Y N Herpes	Y N Psychiatric Problems	Y N Tonsillitis
Y N Cancer	Y N Fainting Spells	Y N High Blood Pressure	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Chemotherapy	Y N Fever Blisters	Y N HIV+/AIDS	Y N Rheumatic Fever	Y N Ulcers
Y N Chicken Pox	Y N Glaucoma	Y N Kidney Problems	Y N Scarlet Fever	Y N Venereal Disease

Please list any serious medical condition(s) that you have experienced: _____

Are you taking any prescription/over the counter drugs? ❑ Yes ❑ No If yes, please list each one: _____

_____

Are you allergic to any of the following?

Y N Aspirin	Y N Codeine	Y N Erythromycin	Y N Latex	Y N Sedatives	Y N Tetracycline
Y N Barbiturates	Y N Dental Anesthetics	Y N Jewelry / Metals	Y N Penicillin	Y N Sulfa Drugs	Y N Other

Please list anything additional that causes allergic reactions: _____

_____

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover. I have received a copy of this offices Notice of Privacy Practices.

_____
Signature Date

VILLAGE DENTISTRY

FINANCIAL POLICY

We appreciate the opportunity to serve you! We have found that a clear understanding of our policy in advance of dental care helps to relieve some of the anxiety associated with dental visits. Please read the following carefully, and ask us any questions you might have.

- **Patients with Insurance:** The estimated patient copay and deductible for treatment rendered must be paid in full on the day of service. We will provide your insurance carrier with all reasonable documentation for you to obtain your benefits from them. You are ultimately responsible for all fees for your treatment.

- **Patients without Insurance:** The fees for treatment rendered must be paid in full on the day of service. We accept Visa, Mastercard, Discover and cash payments. Payment plans are made affordable through Care Credit, which offers a variety of financing plans for needed dental treatment. Please be sure to inquire about this option.

- **Returned checks are subject to a $35.00 charge.**

- **Rescheduled Appointments:** Two business days notice is required for rescheduling appointments. We set aside considerable time for you to receive optimum care while at our office, and without proper advance notice, a $50 fee will be charged to your account if you fail to show up for your appointment, or cancel an appointment less than two days prior.

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This is an agreement between Dr. John H. Upton, Jr. of Village Dentistry, and the Patient named on this form. By executing this agreement, you consent to treatment by Dr. Upton and his staff, and agree to pay for all services received, and to all the terms and conditions contained herein.

Patient Name_____Relationship: Self / Parent / Guardian

Signature_____ Date:_____

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VILLAGE DENTISTRY

John H Upton Jr. DDS
6446 Hwy 179 Suite 201
Castle Rock Plaza
Sedona, AZ 86351

Release of Medical/Dental Information HIPAA form

Patient Name: _____ Date of Birth: ____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Parent(s) _____

[ ] Other _____

[ ] No information is to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home phone [ ] my work number [ ] my cell number

_____ _____ _____

If unable to reach me:

[ ] you may leave a detailed message [ ] please leave me a message asking for a return call

The best time to reach me personally is (day) _____ between (time) _____

Signed: _____ Date: ____/____/_____

Witness: _____ Date: ____/____/_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Arrowhead Dentistry
John H. Upton, Jr., DDS, MAGD

* You May Refuse to Sign This Acknowledgement*

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

_____

Please Print Name

_____

Signature

_____

Date

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____