Sedona Dental Arts, LLC

928-282-1514

Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

PATIENT INFORMATION (Confidential)

Legal Name_____ Preferred Name_____
Address_____ City_____State_____ Zip_____
Home Phone_____ Work Phone_____ Cell Phone_____
Sex: ☐Male ☐Female Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed
Birth Date____/____/____/ Age_____ Soc. Sec. #_____ Drivers Lic._____
E-mail_____ Whom may we thank for referring you?_____
Patient Employer (Parent Employer, if minor) _____
Person to Contact in Case of Emergency_____ Phone_____
Person to Contact in Case of Emergency_____ Phone_____
Primary Physician_____ Phone_____
Orthopedic and/or Heart Doctor_____ Phone_____

RESPONSIBLE PARTY (if different than above)

Person Responsible for this Account_____ Relationship to Pt_____
Address _____ Phone(s)_____

PRIMARY DENTAL INSURANCE INFORMATION

Name of Policy Holder_____ Relationship to Pt_____
Policy Holder Soc. Sec. #_____ Insured Birthdate_____
Group Number_____ Policy ID Number _____
Employer/Ins Group Name_____ Phone #_____
Address_____
Insurance Company Name_____ Phone #_____
Address_____
How Much is your Deductible? $_____ Max. Annual Benefit $_____ Used this year? $_____
DO YOU HAVE ANY SECONDARY DENTAL INSURANCE? ☐Yes ☐No If yes, please ask for a second form.

PATIENT DENTAL HISTORY

Previous Dentist and Location_____ Date of Last Exam_____
Please list problems and concerns_____

	Yes	No		Yes	No
Do your gums bleed while brushing or flossing?	☐	☐	Do you have frequent headaches?	☐	☐
Are your teeth sensitive to hot or cold liquids/foods?	☐	☐	Do you bite your lips or cheeks frequently?	☐	☐
Do you feel pain in any of your teeth?	☐	☐	Have you had difficult extractions in the past?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐	Have you had prolonged bleeding after extractions?	☐	☐
Have you had any orthodontic treatment?	☐	☐	Have you received oral hygiene instruction?	☐	☐
Have you had any of the following problems in your jaw?	☐	☐	Do you like your smile?	☐	☐
Clicking	☐	☐	Would you like for your teeth to be:		
Pain (joint, ear, side of face)	☐	☐	Straighter?	☐	☐
Difficulty in opening or closing	☐	☐	Whiter?	☐	☐
Difficulty in chewing	☐	☐	Other?_____		

Do you wear dentures or partials? ☐ Yes ☐ No If yes, date of placement_____
Do you have trouble sleeping due to snoring? ☐ Yes ☐ No