

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 print this form, fill it out, and bring with you to your appointment. If you have any questions please call us - we will be happy to help. 602-957-5000

1 Personal Information

Date: ____ / ____ / ____

Name: _____ Wishes to be called: _____

Birthdate: ____ / ____ / ____ Age: ____
 Male Female
 Minor Single Married Divorced Widowed Separated

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Referred by: _____

2 Responsible Party

Who is responsible for the account?

Name: _____ Relationship to patient: _____

Birth date ____ / ____ / ____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Work Phone: (____) ____ - ____ Ext.#: ____ Home Phone: (____) ____ - ____

Cell Phone: (____) ____ - ____ e-mail: _____

3 Telephone

Where do you prefer to receive calls? Home Work Cell

When is the best time to reach you? Time: _____ Days: _____

In the event of an emergency, who should we contact?

Name: _____ Relationship to patient: _____

Work Phone: (____) ____ - ____ Ext.#: ____ Home Phone: (____) ____ - ____

Cell Phone: (____) ____ - ____ e-mail: _____

HEALTH HISTORY

Name: _____

Birthdate: ____ / ____ / ____

Date: ____ / ____ / ____

A Dental History

- Reason for visit: _____
 - When was your last dental visit? _____
 - How often do you brush your teeth? _____
 - What texture brush do you use? Soft Medium Hard
- | | Yes | No | | Yes | No |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 5. Do your gums bleed while brushing? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you had any head, neck, or jaw injuries? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do your gums bleed when flossing? | <input type="checkbox"/> | <input type="checkbox"/> | 14. Do you have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you feel pain to any of your teeth when brushing or flossing them? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Do you clench or grind your teeth while awake or asleep? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are your teeth sensitive to hot, cold, sweets or sour foods/liquids? | <input type="checkbox"/> | <input type="checkbox"/> | 16. Do you bite your lips or cheeks frequently? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you noticed any loosening of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> | 17. Have you ever had: | | |
| 10. Does food tend to become caught between your teeth? | <input type="checkbox"/> | <input type="checkbox"/> | a. Orthodontic treatment (braces)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you have any sores or lumps in or near your mouth? | <input type="checkbox"/> | <input type="checkbox"/> | b. Oral surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever experienced any of the following problems in your jaw? | | | c. Gum treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Clicking? | <input type="checkbox"/> | <input type="checkbox"/> | d. Your teeth ground or the bite adjusted? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Pain (joint, ear, side of face)? | <input type="checkbox"/> | <input type="checkbox"/> | e. Worn a bite plane or other appliance? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Difficulty in opening or closing? | <input type="checkbox"/> | <input type="checkbox"/> | 18. Are you satisfied with the appearance of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Difficulty in chewing? | <input type="checkbox"/> | <input type="checkbox"/> | 19. Have you ever had an upsetting experience in the dental office? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 20. Is there anything about having dental treatment that bothers you? | <input type="checkbox"/> | <input type="checkbox"/> |

B Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Are you in good health? | <input type="checkbox"/> | <input type="checkbox"/> | 8. Have you had abnormal bleeding? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have there been any changes in your general health within the past year? | <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you bruise easily? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Date of your last physical exam: ____ / ____ / ____ | | | 10. Have you ever required a blood transfusion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Physicians name: _____ | | | 11. Have you had a recent weight loss? | <input type="checkbox"/> | <input type="checkbox"/> |
| Address: _____ | | | 12. Do you use tobacco? | <input type="checkbox"/> | <input type="checkbox"/> |
| Phone No. (____) ____ - _____ | | | 13. Do you use alcohol or cocaine or other drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you now under the care of a physician? | <input type="checkbox"/> | <input type="checkbox"/> | 14. Are you wearing contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever been hospitalized for any surgical operation or serious illness? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Do you have any disease, condition or problem not listed above that you think I should know about? | <input type="checkbox"/> | <input type="checkbox"/> |
| Please explain: _____ | | | | | |
| 7. Are you taking any medicines(s) including non-prescription medicine? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| If yes, what medicine(s) are you taking? _____ | | | | | |
- Women Only:**
- Are you pregnant or think you might be pregnant?
 - Are you nursing?
 - Are you taking birth control pills?

(Over)

C Dental History Continued...

	Yes	No		Yes	No
Are you allergic to or have you had reactions to:			8. Low blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
1. Local anesthetics like Novocain?	<input type="checkbox"/>	<input type="checkbox"/>	9. Hepatitis, jaundice or liver disease?	<input type="checkbox"/>	<input type="checkbox"/>
2. Penicillin or other antibiotics?	<input type="checkbox"/>	<input type="checkbox"/>	10. Stroke?	<input type="checkbox"/>	<input type="checkbox"/>
3. Sulfa drugs?	<input type="checkbox"/>	<input type="checkbox"/>	11. Sinus trouble?	<input type="checkbox"/>	<input type="checkbox"/>
4. Barbiturates, sedatives or sleeping pills?	<input type="checkbox"/>	<input type="checkbox"/>	12. Lung or breathing problems?	<input type="checkbox"/>	<input type="checkbox"/>
5. Aspirin?	<input type="checkbox"/>	<input type="checkbox"/>	13. Asthma or hay fever?	<input type="checkbox"/>	<input type="checkbox"/>
6. Iodine?	<input type="checkbox"/>	<input type="checkbox"/>	14. Hives or skin rash?	<input type="checkbox"/>	<input type="checkbox"/>
7. Other? _____	<input type="checkbox"/>	<input type="checkbox"/>	15. Fainting spells or seizures?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have or have you ever had the following:			16. Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
1. Rheumatic heart disease or rheumatic fever?	<input type="checkbox"/>	<input type="checkbox"/>	17. AIDS or HIV infection?	<input type="checkbox"/>	<input type="checkbox"/>
2. Scarlet fever?	<input type="checkbox"/>	<input type="checkbox"/>	18. Thyroid problems?	<input type="checkbox"/>	<input type="checkbox"/>
3. Heart defect or heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	19. Allergies?	<input type="checkbox"/>	<input type="checkbox"/>
4. Heart trouble, heart attack, or angina?	<input type="checkbox"/>	<input type="checkbox"/>	20. Arthritis or rheumatism?	<input type="checkbox"/>	<input type="checkbox"/>
a. Do you have pain in your chest upon exertion?	<input type="checkbox"/>	<input type="checkbox"/>	21. Joint replacement or implant?	<input type="checkbox"/>	<input type="checkbox"/>
b. Are you ever short of breath after mild exercise?	<input type="checkbox"/>	<input type="checkbox"/>	22. Stomach ulcer?	<input type="checkbox"/>	<input type="checkbox"/>
c. Do your ankles swell?	<input type="checkbox"/>	<input type="checkbox"/>	23. Kidney trouble?	<input type="checkbox"/>	<input type="checkbox"/>
d. Do you get short of breath when you lie down?	<input type="checkbox"/>	<input type="checkbox"/>	24. Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>
e. Do you require extra pillows when you sleep?	<input type="checkbox"/>	<input type="checkbox"/>	25. Persistent cough?	<input type="checkbox"/>	<input type="checkbox"/>
5. Pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>	26. Cough that produces blood?	<input type="checkbox"/>	<input type="checkbox"/>
6. Heart surgery?	<input type="checkbox"/>	<input type="checkbox"/>	27. Cancer?	<input type="checkbox"/>	<input type="checkbox"/>
7. High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	28. Sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>
			29. Epilepsy/	<input type="checkbox"/>	<input type="checkbox"/>
			30. Anemia?	<input type="checkbox"/>	<input type="checkbox"/>
			31. Leukemia?	<input type="checkbox"/>	<input type="checkbox"/>
			32. Glaucoma?	<input type="checkbox"/>	<input type="checkbox"/>

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature Of Patient, Parent, or Guardian

Date

For Completion By The Dentist:

Summary of Dental History

Summary of Medical History

Medical History Update:

Date	Comments	Patient	Dentist	Hygienist
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____



Arthur Chal

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Accredited ■

American Academy of

Cosmetic Dentistry

Fellow ■

Academy of General Dentistry

Fellow ■

International Congress of

Oral Implantology

CONSENT FOR TREATMENT

1. I hereby authorize Dr. Chal or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by Dr. Chal to make thorough diagnosis.
2. Upon such diagnosis, I authorize Dr. Chal to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I authorize Dr. Chal to release any information, including the diagnosis and the records of any treatment or examination rendered, to other health practitioners and medical or dental health insurance companies, as necessary for my treatment.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service.

Name (Print)

Signature of patient, parent or guardian

Relationship to patient

_____/_____/_____
Date

Signature of guarantor of payment / responsible party

Relationship to patient

_____/_____/_____
Date



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Directions, coming on Arizona State Highway 51, from the north:

Take the Colter St. exit
Keep left at the fork to go on E Colter St.
Turn slight right onto Squaw Peak Pkwy.
Squaw Peak Pkwy becomes N 18th St.
Turn left onto E. Camelback Rd.

Go 1.7 miles

Turn right onto N 32nd St.
Go 1 block, to 4715 N 32nd St.

Our building is on the left (east) side of the road. Turn left into the parking area. The building access is from the rear. The doors are marked "lobby entrance."

Directions, coming on Arizona State Highway 51, from the south:

Take the Indian School Rd. exit (exit 3)
Turn right at E Indian School Rd.
Go 1.7 mi and turn left onto N 32nd St.

Go 0.8 mi., to 4715 N 32nd St.

Our building is on the right (east) side of the road. Turn right into the parking area. The building access is from the rear. The doors are marked "lobby entrance."

Directions, coming from the east or west:

Get on Arizona State Highway 202 (Red Mountain Freeway)

Take the 32nd St. exit (exit 1C)

Go north 3.2 miles

Our building is on the right (east) side of the road. Turn right into the parking area. The building access is from the rear. The doors are marked "lobby entrance."

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of

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