American Institute of Dental Assisting
2500 S. Power Rd. Suite 127
Mesa, Arizona 85209
(480) 209-1392
(480) 807-8394

Patient Information

Contact Information:

Date_____

Name: _____ Marital Status: _____

Social Security Number: _____ Date of Birth: _____

Current Address: _____ City: _____ State: _____ Zip: _____

Permanent Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email address: _____

Reason for coming to our office: _____

When was your last dental visit? _____

Has a family member been treated in this office? ☐ YES ☐ NO **If Yes, Name:** _____

Nearest relative not living with you: _____ Phone: _____

Relative's current Address: _____ City: _____ State: _____ Zip: _____

Financal Responsible Party:

Name: _____ Relationship to Patient:: _____

Social Security Number: _____ Date of Birth: _____

Current Address: _____ City: _____ State: _____ Zip: _____

Permanent Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email address: _____

Previous Address: _____ City: _____ State: _____ Zip: _____

Employers name: _____

Address: _____ City: _____ State: _____ Zip: _____

Responsible Party's Spouse: _____ S.S. #: _____ D.O.B.: _____

Patient Medical / Dental History:

1. Have you every had any of the following illnesses or disorders? If yes, please check.

____Heart Attack	___Rheumatic Fever	___Hepatitis A/B/C (Circle one)	___Cancer
____Heart Disease	___Asthma	___Stomach Ulcer	___Seizures
____Heart Murmur	___Emphysema	___Radiation/Chemotherapy	___Tuberculosis
____Epilepsy	___Venereal Disease	___Angina (chest pain)	___Diabetes
____HIV/AIDS	___Irregular Heart Beat	___Shortness of Breath	___Arthritis
____Sinus Problems	___Artificial Heart Valve	___Thyroid Disease	___Pneumonia
____Kidney Disease	___High Blood Pressure	___Artificial Joint Replacement	___PRE-MED

2. Have you had any disease or illness not listed above? If so, please describe:

_____

3. Have you ever had an operation? If so, please describe:

_____

4. Are you currently taking any medications , drugs, or pills on a **regular basis?** If so, please list:

_____

5. If you are not on any medications currently, but have been on medications, either prescribed by a doctor or obtained without a prescription in the past year, please list medication and dosage:

_____

6. Are you **allergic** or **sensitive** to any medication? YES/NO If so, please list those medications: _____

_____

7. Are you allergic to latex? YES/NO

8. Have you been under the care of a physician during the past 2 years? If so, for what purpose?

_____

9. Have you or a family member ever had any problems with anesthesia (tooth numbing)	YES	NO
10. Are you subject to fainting, dizziness, or nausea?	YES	NO
11. Have you ever had any bleeding problems following surgery?	YES	NO
12. Do you have any limitation of activity or work?	YES	NO
13. (Women) Are you pregnant?	YES	NO
14. Have you used, or do you currently use illegal drugs?	YES	NO

15. Please indicate length of time and daily amount used of each of the following:

Smoking_____ Alcohol _____ Other _____

16. Do your gums bleed when you brush or floss your teeth?	YES	NO
17. Do you grind or clench your teeth?	YES	NO
18. Have you had problems with your temporomandiblar joins (jaw joints)	YES	NO
19. Have you had frequent toothaches?	YES	NO
20. Have you ever worn braces?	YES	NO

21. If you wear dentures, how long have you had them? Upper _____ Lower _____

22. Do you have a history of chemical dependence? YES NO

If yes, how long have you been in recovery? _____

23. Have you taken Cocaine, Methamphetamines or "Ecstasy" in the last 24 hours? YES NO

Please note: The local anesthetic used in this practice could possibly cause a fatal outcome if used on a patient who has done so.

I understand the importance of a truthful health history and realize that incomplete information my have an adverse effect on the outcome of my treatment. To the best of my knowledge, the information contained in this form is complete and accurate and the doctor may rely upon it for treatment decisions.

_____ _____ _____

Date Signature of Patient/Guardian Doctor Initials

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Photo Release

I, _____, give the American Institute of Dental Assisting, L.L.C., the total right and permission to use my photograph in its promotional materials and publicity efforts, without compensation in any form. I understand that the photographs may be used in a publication, print ad, direct-mail piece, electronic media (i.e. video, CD-ROM, Internet/www), or other form of promotion.

Signature_____

Address_____

City_____ State_____ Zip_____

Telephone( )_____

Date: _____

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Disclosure Statement

DISCLOSURE STATEMENT AND AGREEMENT FOR PROFESSIONAL SERVICE IN COMPLIANCE WITH REGULATION Z OF THE FEDERAL TRUTH IN LENDING ACT PAYMENT FOR SERVICES RENDERED IS DUE AND PAYABLE AT THE TIME SERVICES ARE PERFORMED.

Fees charged to you for your consultation and any dental procedures (if necessary) will be estimated and quoted to you at the time of consultation.

Past due accounts, over thirty days from date of service are subject to interest charges of 1.5% per month, with a minimum charge of $5.00 per month. Accounts that are past due will be reported to Credit Data Southwest. In the event that this account is assigned for collection, you agree to pay all court costs, as well as all collection expenses incurred by The American Institute of Dental Assisting. Checks returned by financial institutions for nonpayment are subject to a $30.00 fee per occurrence. You agree to allow The American Institute of Dental Assisting to re-deposit any returned checks electronically or manually at any time without prior notice.

Your signature certifies that all information provided on the Patient Information and Patient Medical History forms is true and accurate. It also confirms that you have read and consvvent to all terms and conditions of the Disclosure Statement. You furthermore authorize us to receive your credit report if we feel that you pose a credit risk to us.

ALL PATIENTS (RESPONSIBLE PARTY) MUST SIGN THIS FORM.

_____ _____

Patient (Responsible Party) Signature Date

_____ _____

Print Name Witness

Dental School Polices

To: American Institute of Dental Assisting Patients,

The American Institution of Dental Assisting is a teaching program with the primary goal of training students to become qualified entry level dental assistants. We are not a normal dental practice, but rather an educational and training facility. Therefore, all guidelines and requirements must be strictly adhered to as follows:

First, all patients must undergo a complete exam and x-rays by a diagnosing dentist. As a result of the exam, the doctor will determine if your dental needs qualify you to be accepted as a patient in the school. Only basic procedures are performed in the institute's clinics, i.e. composite fillings, crowns and extractions. No other dental procedures are offered. In some cases, you may not be a candidate and therefore cannot be treated.

Second, the following guidelines and requirements must be adhered to for you to be scheduled to as a patient in the clinics. Please initial below indicating that you have read and accept all requirements:

_____ You must prepay(deposit) for all services that are scheduled. This deposit reserves your specific appointment time.

_____ The school does not accept insurance payments. At your request, we will print a statement with which you can seek payment from your insurance company.

_____ **It is imperative that you be on time for your scheduled clinic.** The clinic is scheduled around you and a "no show" or late patient creates extreme disruption for the Dentists, Instructors and students and denies them the opportunity to participate in learning hands-on dentistry.

_____ The school is a learning experience. Dentists and Instructors are proceeding slowly while explaining, training and guiding the dental students. Treatment usually takes longer than normal, sometimes up to 3 hours.

_____ Please refrain from questions or conversations during treatment. If you are in pain or have an urgent matter, please inform the treating doctor. Otherwise, reserve your questions and comments until the treatment is completed.

_____ **The American Institute of Dental Assisting does not take the place of your regular dentist.** You are responsible for having your own dentist for routine ongoing dental care. There is no dentist on site at The American Institute Of Dental Assisting during normal business hours for follow up dental care. The only hours a dentist is available is during scheduled clinical appointments.

_____ **If you "no show" or cancel less than 72 hours before the scheduled clinic, your prepayment (deposit) will not be refunded and you will not be rescheduled.**

I have read and understand the requirements listed above and understand that there are no exceptions and I agree completely.

_____

Printed Name Date

_____

Signature Witness