Dr. Daniel C. Sluyk, DDS
8591 E. Bell Rd #101 • Scottsdale, AZ 85260
o: (480) 367-0300 f: (480)699-9403
info@scottsdaleazdentist.com

Welcome to Our Practice

Patient Name: _____ _____ ____ _____
Last First M Preferred Name

Title: _____ Gender: ____ M ____ F Family Status: ____ Married ____ Single ____ Child ____ Other
Mr/Dr/Mrs/Ms

Birth Date: _____ SSN: ____ - ____ - _____ Date of Last Dental Visit: _____ Last X-Rays: _____

Email Address: _____ Best time to call: _____

Phone: _____ _____ _____ _____ _____
Home Mobile Work Ext Other

Address: _____ Address 2: _____

City: _____ State: _____ Zip Code: _____

Name of Previous Dentist: _____

Whom may we thank for referring you to our practice? _____

In an emergency, who should be notified? Please enter Name and Phone Number: _____

The following is for: ____ the patient ____ the person responsible for payment ____ both ____ not applicable

Employer Name: _____ Phone: _____

Employer Address: _____ Address 2: _____

City: _____ State: _____ Zip Code: _____

*Please make sure all fields above are completed to ensure timely verification of benefits and estimation of copays.

Medical History Form

Patient Name: _____ Date: _____

Check all of the following that you may have had in the past or that currently apply to you:

☐ AIDS/HIV Positive	☐ Congenital Heart Disease	☐ High Blood Pressure	☐ Sinus Trouble/Infections
☐ Alzheimer's Disease	☐ Dementia	☐ Irregular Heartbeat	☐ Sleep Apnea-CPAP
☐ Anemia	☐ Diabetes: A1C_____	☐ Kidney Problem/Disease	☐ Sores/Growths in Mouth
☐ Angina	☐ Elevated Cholesterol	☐ Liver Problem/Disease	☐ Stroke
☐ Arthritis	☐ Emphysema/COPD	☐ Low Blood Pressure	☐ Thyroid Disease
☐ Artificial Joint	☐ Epilepsy or Seizures	☐ Lung Disease	☐ Tuberculosis
☐ Asthma	☐ Excessive Bleeding	☐ Mitral Valve Prolapse	☐ Tumors or Growths
☐ Atrial Fibrillation	☐ Fainting/Dizzy Spells	☐ Pacemaker/Defibrillator	☐ Ulcer
☐ Blood Disease	☐ Glaucoma	☐ Parathyroid Disease	☐ Other: _____
☐ Blood Transfusion	☐ Gout	☐ Psychiatric Care	
☐ Bruise Easily	☐ Heart Attack_____	☐ Radiation Treatment	
☐ Cancer: _____	☐ Heart Disease	☐ Renal Dialysis	
☐ Chemotherapy	☐ Heart Murmur	☐ Rheumatic Fever	
☐ Chest Pains	☐ Hemophilia	☐ Scarlet Fever	
☐ Cognitive Disorders	☐ Hepatitis A, B, or C	☐ Shingles	
☐ Cold Sores/Fever Blisters	☐ Herpes	☐ Sickle Cell Disease	

Are you allergic to or have you reacted adversely to any of the following medications? Please check all that apply.

☐ Aspirin	☐ Erythromycin	☐ Tetracycline	☐ Codeine	☐ Latex
☐ Penicillin/Amoxicillin	☐ Sulfa	☐ Local Anesthetic	☐ Other:	

Have you ever taken any of the following medications? Please check all that apply, and provide start/end dates.

☐ Actonel	☐ Boniva	☐ Risedronate
☐ Alentronate	☐ Fosamax	☐ Zometa
☐ Aredia	☐ Reclast	☐ Prolia/Denosumab
☐ Herbal Supplements:		

Are you currently taking any medications? If yes, please list: _____

Do you need antibiotics prior to receiving dental care? If so, which type/dosage? _____

Do you take Coumadin or Plavix or any other blood thinner? If yes, do you know your typical INR? _____

Please describe your present health (circle one) Excellent / Good / Fair / Poor / Don't Know

When was your last visit with your primary care physician? _____

Are you currently under a physician's care? If yes, please list reason: _____

Has there been any change in your general health in the past year? If yes, please explain: _____

Please list any other serious illness, hospitalization, or condition in the last 5 years if not listed above: _____

Are you a past or present smoker/vaper? Yes ☐ No ☐ If yes, how many cigarettes/cigars/mg per day? _____

Do you have any history of substance abuse, or do you currently use recreational drugs? Yes ☐ No ☐

The above information on this form has been accurately answered and is true to the best of my knowledge. I understand that providing incorrect information can be dangerous to my or the patient's health. I understand that it is my responsibility to inform Dr. Daniel C. Sluyk, DDS of any changes in my or the patient's medical status.

Patient/Guardian signature: _____ Date: _____

Dental Insurance

Primary Dental Insurance

Insurance Plan Name: _____ Phone Number for Provider Services: _____

Name of Insured: _____ _____ ____
Last First M

Insured's Birth Date: _____ Plan ID #_____ Insured's SSN: ____ - ____ - _____ Group # _____

Insured's Address: _____ Address 2: _____

City: _____ State: _____ Zip Code: _____

Patient's Relationship to insured: ____ Self ____ Spouse ____ Child ____ Other

Secondary Dental Insurance

Insurance Plan Name: _____ Phone Number for Provider Services: _____

Name of Insured: _____ _____ ____
Last First M

Insured's Birth Date: _____ Plan ID #_____ Insured's SSN: ____ - ____ - _____ Group # _____

Insured's Address: _____ Address 2: _____

City: _____ State: _____ Zip Code: _____

Patient's Relationship to insured: ____ Self ____ Spouse ____ Child ____ Other

Insurance Authorization - please complete for payment of insurance benefit

☐ By checking this box,

I authorize my insurance(s) to pay my benefits directly to the dentist for all services rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges, whether or not paid by insurance.

*Please make sure all fields above are completed to ensure timely verification of benefits and estimation of copays.

Dental Information

How would you rate the condition of your mouth? ____ Excellent ____ Good ____ Fair ____ Poor

How often do you routinely see your dentist? ____ 3 mo. ____ 4 mo. ____ 6 mo. ____ 12 mo. ____ Not routinely

What is your immediate concern?

_____

_____

Are you fearful of dental treatment? If yes, how fearful, on a scale or 1 (least) to 10 (most) _____

Personal history, check all that apply:

☐ Had an unfavorable dental experience	☐ Had complications from past dental treatment	☐ Had trouble getting numb
☐ Had any reactions to local anesthetic	☐ Had/have braces, orthodontic treatment	☐ Had your bite adjusted
☐ Had any teeth removed		

Smile Characteristics, check all that apply:

☐ Is there anything about the appearance of your teeth that you would like to change?	☐ Have you felt uncomfortable or self-conscious about the appearance of your teeth?
☐ Have you ever whitened (bleached) your teeth?	☐ Have you been disappointed with the appearance of previous dental work?

Bite and Jaw Joint, check all that apply:

☐ You have problems with your jaw joint	☐ You chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits
☐ You have any problems chewing	☐ You clench your teeth in the daytime or make them sore
☐ Your teeth changed in the last 5 years, have become shorter, thinner, or worn	☐ You have problems with sleep, or wake up with an awareness of your teeth
☐ Your teeth are crowding or developing spaces	☐ You wear or have worn a bite appliance

Tooth Structure, check all that apply:

☐ Cavities within the past 3 years	☐ The amount of saliva in your mouth seems too little, or you have difficulty swallowing food	☐ You notice or have holes (i.e., pitting, craters) on the biting surface of your teeth
☐ Your teeth are sensitive to hot, cold, biting, sweets, or you avoid brushing any part of your mouth	☐ Your teeth have grooves, notches, chips, a cracked filling, or pain	☐ Food gets caught between your teeth

Gum and Bone, check all that apply:

☐ Gums bleed when brushing or flossing	☐ Treated for gum disease or were diagnosed with bone loss	☐ Noticed an unpleasant odor or taste in your mouth	☐ History of periodontal disease in your family
☐ Experienced gum recession	☐ Had any teeth become loose on their own (without injury) or have difficulty eating an apple	☐ Experienced a burning sensation in your mouth	

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements must be paid for in cash at the time services are performed unless other arrangements have been made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for the payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

Patient or Guardian Signature: _____ Date _____

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records who release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my health care will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Patient or Guardian Signature: _____ Date _____

Informed Consent for Local Anesthesia

I understand that my dental treatment may require the use of a local anesthetic for pain control. I understand that a local anesthetic may consist of different medications that are injected into the cheek, jaw, or gum area. These drugs may include lidocaine, prilocaine, mepivacaine, bupivacaine, articaine, or others. I understand that local anesthetics may contain a "vasoconstrictor" like epinephrine; antioxidants, such as sulfites or methylparaben for preservation of the solutions; sodium hydroxide, and sodium chloride.

I understand that local anesthetics will cause a section of my mouth to become numb, with the numbness lasting up to several hours. I know that while my mouth is numb, I must be careful not to bite my lips or tongue.

Local anesthetics are among the most common drugs used in a dental office. Complications and side effects are rare, but may include, among others not listed below:

- Swelling, bruising, or soreness at the injection site
- A blood-filled swelling called hematoma, can form when a needle used during an injection hits a blood vessel
- Temporary numbness outside of the mouth making an eyelid or mouth "droop"
- Temporary rapid heartbeat
- Damage to the nerves resulting in temporary or possibly permanent numbness or tingling of lips, chin, tongue or other areas
- Severe and possible life-threatening allergic reactions necessitating emergency care

I understand that if I have uncontrolled high blood pressure, uncontrolled thyroid problems, angina, or have recently had a heart attack, I will inform my dentist without fail as these conditions have caused complications for persons receiving local anesthesia. I will also inform the dentist of any prescription or over-the-counter medications I am taking as these may interact with local anesthetics. I understand my dentist's recommendation of local anesthetic for all the dental procedures that requires adequate pain control, risks of the local anesthetics, any alternatives and risks of these alternatives, including consequences of doing nothing. This consent for local anesthetic remains valid every time I seek any treatment in this office. I have had all my questions answered and have not been offered any guarantees.

Patient or Guardian Signature: _____ Date _____

Social Media & Photography/Video Consent

I agree to grant the following rights and permissions to Dr. Daniel Sluyk to take full-face photographs and/or video images of me for marketing purposes. I understand my photographs will be used specifically for, but not limited to, advertisement purposes, print media and distribution over the internet for illustration, promotion, art, editorial advertising, trade, or any other purpose whatsoever.

I hereby warrant that I have the right to contract in my own name. I have read the above authorization, release, and agreement, prior to its execution, and I am fully familiar with the contents of this document.

Patient or Guardian Signature: _____ Date _____

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purpose, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to activate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

Patient or Guardian Signature: _____ Date _____