EVERGREEN
DENTAL CARE

Office Phone Number: 480-831-6640
Email to: info@evergreen-dentalcare.com

New Patient Information:

Patient Name: _____

Preferred Name: _____

Title (Mr./Mrs./Dr./etc): _____

Gender: **Male ____ Female ____**

Family Status: **Married ____ Single ____ Child ____ Other ____**

Birthdate: _____ Social Security Number: _____

Email Address: _____ Phone Number: _____

Address:_____

City:_____ State:_____ Zip: _____

Insurance Information

Do you have dental insurance? **Yes ____ No ____**

If not, ask us about our in-house dental plan.

Name of Insured: _____

Patient's relationship to insured: **Self ____ Spouse ____ Child ____ Other ____**

Insured's Birthdate: _____

ID Number: _____ Group Number: _____

Insurance Plan Name: _____ Insured's Social Security Number: _____

Insured's Employer Name: _____

How did you hear about our Practice?

Facebook ____ Website ____ Insurance Company ____ Google Search ____

Friend/Family Member: _____ Other: _____

EVERGREEN
DENTAL CARE

Office Phone Number: 480-831-6640
Email to: info@evergreen-dentalcare.com

Health History Update:

Patient Name: _____

Within the past year, have there been any changes to your general health? **Yes ____** **No ____**

If yes, please explain:

_____

_____

Primary Care Physician's Name and phone Number:

_____

Please List Medications:

_____

_____

Women Only: Are you pregnant? **Yes ____** **No____**

If yes, when is your due date? _____

Are you currently undergoing IVF Treatment? **Yes ____** **No ____**

Please circle all that apply to you:

Allergies	Blood Thinners	Liver Disease
Latex Allergy	Fainting	Mental Disorders
Codeine Allergy	Head Injuries	Nervous Disorders
Penicillin Allergy	History of Stroke	Pacemaker
Artificial Joints	History of Heart Attack	Radiation Treatment
Asthma	Heart Disease or Ailments	Chemotherapy
Blood Disease	Heart Murmur	Respiratory Problems
Cancer	Hepatitis	Sinus Problems
Diabetes (Type 1 or Type 2)	HIV	Migraines
Dizziness	High Blood Pressure	Stomach Problems
Epilepsy	Kidney Disease	Tobacco Use

EVERGREEN
DENTAL CARE

Office Phone Number: 480-831-6640
Email to: info@evergreen-dentalcare.com

Please elaborate further on above circled conditions:

_____

_____

Any other health issues or allergies not noted above?

_____

_____

Dental History Update:

Do you have any concerns today?

_____

_____

Do you have or wear a night guard? **Yes ____ No ____**

Do you have or wear retainers? **Yes ____ No ____**

Would you be interested in having straighter Teeth? **Yes ____ No ____**

Have we ever discussed the possibility of gum disease or infection in the gum tissue in the past?

Yes ____ No ____ Unsure ____

Please circle all that apply today:

Broken Teeth	Bleeding Gums	Bad Breath or Odor
Food Catching	Crooked Teeth	Sores or Growths in Mouth
Sensitivity to Biting	Chipped Teeth	Grinding/Clenching
Sensitivity to Hot/Cold	Sensitive to Sweets	Vape/Tobacco Usage

Any Other Dental Concerns

_____

_____

EVERGREEN
DENTAL CARE

Office Phone Number: 480-831-6640
Email to: info@evergreen-dentalcare.com

How would you rate your dental anxiety/fear? (1 = none, 10 = greatest fear)

1 2 3 4 5 6 7 8 9 10

To help with your comfort, are you interested in any of the following?
Headphones/Music ____ Blanket/Pillow ____ Oral Sedation Medication ____ Nitrous Gas ____

GENERAL INFORMED CONSENT

I hereby authorize Drs. John Lopez and William Blocher, to take the necessary X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Drs. John Lopez and William Blocher to make a thorough diagnosis of the patient's dental needs. I also authorize Drs. John Lopez & Wm Blocher, to perform all forms of treatment, medication, and therapy that may be indicated. I also understand that the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier and not between Drs. John Lopez and William Blocher, and your insurance company. I fully understand that it is my financial responsibility for all dental treatment, regardless of insurance coverage.

HIPAA PRIVACY FORM

*Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices (found in our office) or to document our good faith effort to obtain that acknowledgment may refuse to sign this acknowledgment***

I, _____, have received a copy OR read the explanation of this office's Notice of Privacy Practices.

_____ {Date}_____

{Signature of Patient and/or Guardian}

Office Phone Number: 480-831-6640
Email to: info@evergreen-dentalcare.com

{Relationship to Patient} **Self** ____ **Othe**r: _____

I, _____, acknowledge and allow Drs. John Lopez and William Blocher, to share my information with the following people, besides those already stated within the Notice of Privacy Practices.

( ) I authorize the release of information, including the diagnosis, records, and examination rendered to me, and claims information. This information may be released to:
( ) Spouse _____
( ) Child(ren) _____
( ) Other _____
( ) No information is to be released to anyone.

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

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

Please call my cell number: _____ My work number: _____

If unable to reach me: ( ) you may leave a detailed message ( ) Permission to Text/email me.

Signed: _____ Date: ____/____/_____

EVERGREEN
DENTAL CARE

Office Phone Number: 480-831-6640
Email to: info@evergreen-dentalcare.com

Our Financial Philosophy

Patient's Role

As with any partnership, both parties have a role to play. Our role is to provide you with quality service. In turn, your role is to pay for your treatment at time of service. Our team will work with you to determine financial arrangements that make sense for both of us. With an agreement made, our joint follow-through will result in a win for everyone.

So that we may file your insurance claim(s) correctly, we ask all patients to complete our Information and Insurance Form before seeing the doctor as that ensures our office of obtaining the correct information to better serve you in regard to your benefits.

Regarding Insurance

We file insurance claims for all patients with insurance benefits. We accept assignment of insurance benefits; however, the balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your complete insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid on your claim within 45 days, the full balance will automatically be transferred to you. That balance will be due upon billing.

We very much appreciate your prompt payment upon receipt of our services. In the event that your insurance company denies payment of a service, you are responsible for that fee. Any unpaid balance after insurance pays is due within 45 days.

WE ACCEPT CASH, CHECKS, OR MASTERCARD, VISA, AMERICAN EXPRESS. Ask us about EASY PAY OPTIONS. WE OFFER ACCESS TO EXTENDED PAYMENT PLANS WITH CREDIT APPROVAL, which you can give consent to Drs. John Lopez and William Blocher, for a credit check. A third-party resource that allows payments up to 6 months with approved credit.

EVERGREEN
DENTAL CARE

Office Phone Number: 480-831-6640
Email to: info@evergreen-dentalcare.com

I understand that any unpaid balance after 60 days is charged a yearly finance charge of 18%. I further understand that this finance charge is equal to 1.5% of my outstanding balance per month. I understand that if my account reaches collection status (90 days) and I make no effort to pay off my account, my account will be assigned to a collection attorney or agency. If Drs. John Lopez and William Blocher must take additional steps to collect my account. I will pay ALL costs of collection, including court costs and attorney's fees incurred by Drs. John Lopez and William Blocher. I give consent for any credit check to be completed by Drs. John Lopez & Wm Blocher, should it be deemed necessary.

I have read the Financial Philosophy. I understand, accept, and agree to this Financial Philosophy.

_____ _____

Signature of Patient or Responsible Party Date