WOODRUFF FAMILY DENTAL

Parker Woodruff, DMD
10184 W Happy Valley Pkwy, Suite 195, Peoria, AZ 85383
(623) 486 – 2640 | www.WoodruffFamilyDental.com

New Patient Information Form

Welcome to Woodruff Family Dental. Completing this form helps us provide care tailored to you.

Today's Date _____ Patient Number _____

Patient Information

First Name _____ MI _____ Last Name _____

Preferred Name _____ ☐ Male ☐ Female

Address _____

City _____ State _____ Zip _____

DOB _____ Social Security No. _____

Home Phone _____ Cell Phone _____

Work Phone _____ Primary (please check one) ☐ Home ☐ Cell ☐ Work

Email _____

Driver's License No. _____

Employer _____ Spouse's Name _____

Occupation _____ Spouse's Employer _____

How did you hear about us?

☐ Referred by a Friend or Family Member _____

☐ Google Search ☐ Facebook / Instagram ☐ Drive by ☐ Insurance Directory
☐ Google / Apple Maps ☐ Our website ☐ Mailer / Postcard ☐ Other

If the patient is a child:

Parent/Guardian _____ Phone _____

Dental History

Reason for today's visit _____

Are you currently in pain? ☐ Yes ☐ No

If so, please describe _____

Do you have any dental problems now? ☐ Yes ☐ No

If so, please describe _____

Have you ever had trouble with a previous dental treatment? ☐ Yes ☐ No

If so, please describe _____

Level of anxiety about seeing the dentist: (least) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (most)

Date of last dental exam _____ Date of last cleaning _____ Date of last full mouth x-rays _____

Procedure(s) done at last dental visit _____

Previous Dentist's Name _____

City _____ State _____ Phone _____

Why are you changing dentists? _____

Do you require antibiotics before dental treatment?	☐ Yes ☐ No	Do you have frequent headaches?	☐ Yes ☐ No
Do your gums ever bleed?	☐ Yes ☐ No	Do you clench or grind your teeth?	☐ Yes ☐ No
Are your teeth sensitive to heat/cold?	☐ Yes ☐ No	Do you snore loudly?	☐ Yes ☐ No
Have you noticed any mouth odors or bad tastes?	☐ Yes ☐ No	Do you often wake up feeling tired?	☐ Yes ☐ No

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Have you ever had a sleep study or been told you should have a sleep study?	☐ Yes ☐ No
Have you ever been diagnosed with sleep apnea?	☐ Yes ☐ No
Do you currently use a CPAP machine, or have you been told you should use a CPAP machine?	☐ Yes ☐ No

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Have you ever had:

Periodontal disease / deep cleanings	☐ Yes ☐ No	Discomfort in your jaw (TMJ / TMD)	☐ Yes ☐ No
Orthodontic treatment	☐ Yes ☐ No	Serious injury to your mouth or head	☐ Yes ☐ No
A mouth guard	☐ Yes ☐ No		

If yes to any of the above, please describe _____

_____

Is there anything else about your past dental treatment(s) that you would like us to know? _____

_____

Medical History

Have you been hospitalized in the past 5 years? ☐ Yes ☐ No

If yes, explain _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Physician's Name _____ Phone _____

Are you currently taking any medications? ☐ Yes ☐ No

If yes, explain _____

Do you use tobacco? ☐ Yes ☐ No

Women only:

Are you pregnant or think you may be pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No
Are you taking birth control pills? ☐ Yes ☐ No

Indicate which of the following you have had or have at present:

AIDS / HIV	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Lupus	☐ Yes ☐ No
Alcohol / Drug Abuse	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Allergies or Hives	☐ Yes ☐ No	Fainting or Dizzy Spells	☐ Yes ☐ No	Nervousness / Anxiety	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Neurological Disorders	☐ Yes ☐ No
Arthritis / Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Psychiatric /	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Psychological Care	
Artificial Bone / Joints	☐ Yes ☐ No	Heart Disease / Attack	☐ Yes ☐ No	Radiation Therapy	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Rheumatic / Scarlet Fever	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Heart Pacemaker	☐ Yes ☐ No	Sickle Cell Disease / Traits	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Heart Surgery	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Hemophilia /	☐ Yes ☐ No	Snoring / Sleep Apnea	☐ Yes ☐ No
Cancer / Chemotherapy	☐ Yes ☐ No	Abnormal Bleeding		Stomach Problems/Ulcers	☐ Yes ☐ No
Chest Pain	☐ Yes ☐ No	Hepatitis A B C (circle)	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Cold Sores / Herpes	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Diabetes (Type 1)	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tuberculosis (TB)	☐ Yes ☐ No
Diabetes (Type 2)	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Tumors	☐ Yes ☐ No
Diet (Special / Restricted)	☐ Yes ☐ No	Kidney Trouble	☐ Yes ☐ No		
Difficulty Breathing	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No		

Please list any serious medical condition(s) that you have / had that are not listed above: _____

_____

Have you ever had surgery? ☐ Yes ☐ No

If yes, explain _____

Have you ever in the past, or are you currently taking bisphosphonates or any other medication for osteopenia / osteoporosis or bone disease? ☐ Yes ☐ No

If yes, list the medication _____

Are you allergic to any medications or latex? ☐ Yes ☐ No

If yes, explain _____

Signature _____ Date _____

If the patient is a child, parent or guardian signature

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Financial Policy

Thank you for choosing Woodruff Family Dental for your care. We are committed to providing you with the best dental treatment and ensuring you understand your financial responsibility. Please review the following policies carefully.

Patient Responsibility

- Payment for all services is the responsibility of the patient, regardless of insurance coverage.
- For patients under 18, the parent / guardian who accompanies the child to the appointment is financially responsible.

Insurance

- As a courtesy, we will verify your benefits and file claims on your behalf. Please note that benefit information provided by your insurance company is not a guarantee of payment.
- Any portion not covered by insurance (deductibles, co-pays, non-covered services) is due at the time of service.
- If your insurance has not paid within 90 days, the balance becomes your responsibility (you may still collect benefits directly from your insurance carrier). Balances are due upon receipt of your statement[1].

Payment Options

We accept:

- Cash, debit, check[2], and major credit cards
- HSA / FSA cards
- Convenient monthly payment plans from CareCredit[3]

Estimates & Treatment Plans

- Treatment plans are based on the best information available at the time but are only estimates. Your actual costs may vary depending on insurance payment.
- You are responsible for any balance after your insurance has processed your claim.

Cancellations & Missed Appointments

- We kindly request at least 48-hour notice for cancellations or rescheduling.
- Appointments cancelled or missed without 48-hour notice may result in a $50 fee.
- Multiple missed appointments may result in limited scheduling availability.

Agreement

I have read and understand the financial policy of Woodruff Family Dental. I agree to be responsible for all charges incurred for my treatment or the treatment of my dependents.

Signature _____ Date _____

If the patient is a child, parent or guardian signature

[1] Accounts 30+ days past due may be subject to late fees. Accounts 90+ days past due may be referred to collections.
[2] A fee of $25 will be charged for any returned checks
[3] Subject to credit approval

Primary Insurance

Subscriber Name _____

Relationship to Patient _____ DOB _____

Address _____ Phone _____

City _____ State _____ Zip _____

Phone _____

Employer _____ Work Phone _____

Work Address _____

Insurance Company _____

Group # _____ Subscriber ID / Member ID _____

Name of other dependents covered under this plan _____

_____

Secondary Insurance

Is the patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____

Relationship to Patient _____ DOB _____

Address _____ Phone _____

City _____ State _____ Zip _____

Phone _____

Employer _____ Work Phone _____

Work Address _____

Insurance Company _____

Group # _____ Subscriber ID / Member ID _____

Name of other dependents covered under this plan _____

_____

WOODRUFF FAMILY DENTAL

North Peoria's Premier Dental Experience
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Notice of Privacy Practices

Effective Date: September 2025

Your privacy is important to us. This notice describes how your dental and medical information may be used and disclosed and how you can access this information. Please review it carefully.

Our Legal Duty

Woodruff Family Dental is required by law to maintain the privacy of your protected health information (PHI) and to provide you with this Notice of Privacy Practices. We must follow the terms of this notice while it is in effect.

We reserve the right to change our privacy practices and make the new provisions effective for all PHI we maintain. Any changes will be posted in the office and on our website.

How We May Use and Disclose Your Health Information

For Treatment:

- We may use or share your information to provide, coordinate, or manage your dental care.
- Example: Sharing X-rays with a specialist or lab.

For Payment:

- We may use or share your information to bill and receive payment for services.
- Example: Sending a claim to your insurance company.

For Health Care Operations:

- We may use or share information for quality improvement, staff training, or auditing.

Other Permitted Uses:

- Appointment reminders (phone, text, email)
- Treatment alternatives or health-related benefits and services
- As required by law (public health reporting, court orders, law enforcement)

Uses and Disclosures Requiring Your Written Authorization

We must obtain your written authorization for:

- Most uses and disclosures of psychotherapy notes
- Marketing purposes (other than certain face-to-face communications)
- Sale of PHI

You may revoke your authorization in writing at any time, except to the extent we have already acted on it.

Your Privacy Rights

- Access: You may inspect and obtain a copy of your PHI. A fee of $25 may be charged for any requested copies, plus the cost of postage if you request the copies be mailed to you.
- Amendment: You may request corrections to your PHI.

- Accounting of Disclosures: You may request a list of disclosures of your PHI.
- Restrictions: You may request limits on uses or disclosures. We are not required to agree but will consider all requests.
- Confidential Communications: You may request alternative methods of contact (phone, email, mail).

Data Security

Woodruff Family Dental takes reasonable administrative, physical, and technical safeguards to protect your PHI from unauthorized access, use, or disclosure. This includes secure electronic recordkeeping, password-protected systems, and staff training on privacy practices. While we take these precautions, no electronic transmission or storage system is completely risk-free.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with:

- Woodruff Family Dental Privacy Officer: Parker Woodruff, DMD
- U.S. Department of Health and Human Services, Office for Civil Rights: www.hhs.gov/ocr

No retaliation will occur for filing a complaint.

Contact Information

Woodruff Family Dental
10184 W Happy Valley Pkwy, Suite 195, Peoria, AZ 85383
Phone: (623) 486 – 2640
Email: FrontDesk@WoodruffFamilyDental.com

Privacy Officer: Parker Woodruff, DMD

Acknowledgment of Receipt

I acknowledge that I have received or been offered a copy of Woodruff Family Dental's Notice of Privacy Practices.

Signature _____ Date _____

Relationship to Patient (if signed by guardian) _____

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Email: FrontDesk@WoodruffFamilyDental.com

Authorization to Request Dental Records

Date _____

Patient Information

First Name _____ MI _____ Last Name _____

Address _____

City _____ State _____ Zip _____

DOB _____ Phone _____

Release Records From:

Name of Facility / Provider _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Release Records To:

Woodruff Family Dental
10184 W Happy Valley Pkwy, Suite 195, Peoria, AZ 85383
Phone: (623) 486 – 2640 | Fax: (623) 566 – 4727

Purpose of Disclosure: ☐ Continuity of Care ☐ Personal Records ☐ Insurance ☐ Other _____

Information to Be Released

Please indicate which records you would like released:

☐ Complete Dental Record ☐ X-rays / Imaging ☐ Billing / Insurance Records

☐ Treatment Notes / Clinical Summary ☐ Periodontal Charting ☐ Other _____

Authorization

I hereby authorize the above-named office to release my dental records to Woodruff Family Dental as indicated above. I understand:

1. I may revoke this authorization at any time, except to the extent that action has already been taken.
2. Information released may include records protected under HIPAA.
3. Fees may be charged by the releasing office for copying or sending records.

Signature _____ Date _____
If the patient is a child, parent or guardian signature

Office Use Only:
Date Sent: _____ Requested By: _____ Date Received: _____ Method: _____