

Welcome

K. Michael Hood, D.D.S

4602 N. 16th St., Suite 302 Phoenix, Arizona 85016

Thank you for trusting us with your dental care. We promise to do our best to provide you
With the finest care available. If you have any questions, please don't hesitate to call us.

PATIENT INFORMATION

Patient's Name _____ Preferred Name _____
SS# _____ Marital Status

S	M	W	D	O
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 Birthdate ____ / ____ / ____ Age _____
Email Address _____ Pharmacy Name _____ Phone _____
Street Address _____ City _____ State _____ Zip _____
Patient's Employer _____ Occupation (indicate if student) _____
Employer's Street Address _____ City _____ State _____ Zip Code _____
Referred By (Name) _____ Family Physician (Name) _____
 Friend / Family Doctor Insurance Co. Other _____

PHONE NUMBERS

Home _____ Work _____ Ext. _____ Cell _____ Spouse's Work _____
Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____
Home Phone _____ Work Phone _____ Cell Phone _____

ADDITIONAL INFORMATION

Spouse's / Partner's Name	SS#	Birthdate	/
Spouse's / Partner's Employer	Occupation (indicate if student)	Bus. Phone#	
If Patient is a Minor, Please Complete Mother	Birthdate	Employed By	Bus. Phone#
SS#	/	/	
Father	Birthdate	Employed By	Bus. Phone#
SS#	/	/	

INSURANCE INFORMATION

Primary Insurance Name and Address of Company _____ Group# _____ Phone _____
SS# OR ID# _____ Subscriber _____ Group Name and Phone# _____
Secondary Insurance Name and Address of Company _____ Group# _____ Phone _____
SS# OR ID# _____ Subscriber _____ Group Name and Phone# _____

Please complete reverse side

HEALTH QUESTIONNAIRE

NAME OF PHYSICIAN _____

PHYSICIAN'S TELEPHONE NUMBER _____

PHYSICIAN'S FAX NUMBER _____

PLEASE "X" EACH BOX IF THE ANSWER IS "YES", LEAVE BLANK IF "NO"
HAVE YOU HAD...

- | | | |
|---|---|---|
| <input type="checkbox"/> AIDS, ARC, HIV + | <input type="checkbox"/> EXCESSIVE BLEEDING | <input type="checkbox"/> NERVOUS PROBLEMS |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> HEART PROBLEMS | <input type="checkbox"/> PHEN-FEN |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> HEPATITIS A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> | <input type="checkbox"/> PROSTHETIC VALVES/JOINTS |
| <input type="checkbox"/> CEREBRAL PALSY | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> RADIATION TREATMENTS |
| <input type="checkbox"/> CHRONIC SINUS | <input type="checkbox"/> KIDNEY PROBLEMS | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> CIRCULATORY PROBLEMS | <input type="checkbox"/> LATEX ALLERGY | <input type="checkbox"/> SCARLET FEVER |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> LOW BLOOD PRESSURE | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> DRUG USE (ILLEGAL) | <input type="checkbox"/> MALIGNANCIES | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> MITRAL VALVE PROLAPSE | <input type="checkbox"/> VENEREAL DISEASE/HERPES |

Other health complications not listed above _____

If any box is checked please explain: _____

Are you allergic to:

- Penicillin Codeine Local anesthetics (i.e. Novocaine)
- Other: _____

Are you pregnant? Yes No If yes, how many months? _____

Please list all medications you are currently taking: _____

Please list any other medical conditions you feel the doctor should be aware of: _____

Have you ever been hospitalized? Yes No If yes, please explain: _____

MEDICAL HISTORY UPDATES FOR SUBSEQUENT VISITS

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS	PATIENT SIGNATURE	B.P.	REVIEWED BY
_____	_____	NONE <input type="checkbox"/> _____	_____	DR. _____
_____	_____	NONE <input type="checkbox"/> _____	_____	DR. _____
_____	_____	NONE <input type="checkbox"/> _____	_____	DR. _____
_____	_____	NONE <input type="checkbox"/> _____	_____	DR. _____
_____	_____	NONE <input type="checkbox"/> _____	_____	DR. _____

DENTAL HISTORY

Reason for today's visit _____ Former Dentist _____

City/State _____ Date of last dental visit _____ Date of last dental x-rays _____

If you had a magic wand, what would you change about your teeth? _____

Have you ever considered whitening your teeth? Yes No

If you could whiten your teeth in about an hour, would you be interested? Yes No

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT ****

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

FOR ALL PATIENTS

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office. I FURTHER AGREE TO PAY ALL FINANCE CHARGES, COLLECTION COSTS, ATTORNEYS FEES, AND ANY OTHER COST THAT MAY BE INCURRED TO ENFORCE COLLECTION OF ANY AMOUNT OUTSTANDING.

SIGNATURE OF RESPONSIBLE PART _____ RELATIC IIP _____ DATE _____