DENTAL ON CENTRAL

Cancellation Policy

In an effort to provide the highest quality of care to our patients, we have scheduled your appointment time with your convenience in mind. This appointment time has been reserved specifically for you.

As a courtesy to all of our patients, we provide a reminder call to confirm all scheduled appointments, because we understand that your time is valuable and that you often have busy schedules. We also provide the option of email and text confirmations for your appointment.

If for any reason you need to cancel or reschedule your appointment, we kindly ask that you give us **48 hour** advance notice, otherwise there will be a **$75.00 cancellation fee** charged to your account per hour reserved for your treatment.

We value our patients and look forward to caring for you and your dental needs.

If you have any questions regarding this Cancellation Policy, please don't hesitate to contact us at 602-266-1776.

DENTAL ON CENTRAL

Patient Signature:_____ Date:_____

DENTAL ON CENTRAL

INDEPENDENT CONTRACTOR DISCLOSURE

Anthony E. Herro, DDS owns Anthony E. Herro, DDS, PLLC, doing business under the registered trade name of Dental On Central at this location. Most office staff are Anthony E. Herro, DDS, PLLC employees, but not Dr Ellison F Herro MD, Dr Joseph Santoro, Dr Percy Twine, Dr Tamer El Gendy, or Dr Patel. Drs. Santoro, Twine, El Gendy and Patel are licensed dentists in the State of Arizona, and are independent contractors. Dr Ellison F Herro MD is an Anesthesiologist and a licensed physician in the State of Arizona, and is an independent contractor.

I understand that Drs Ellison Herro, Santoro, Twine, El Gendy and Patel are independent contractors at this location and not employees of either Anthony Herro, DDS, or Anthony E. Herro, DDS, PLLC or Dental On Central.

Signature: _____ Date: _____

REGISTRATION

DENTAL ON CENTRAL

PATIENT INFORMATION (CONFIDENTIAL)

NAME:_____ DATE:_____
FIRST MI LAST

ADDRESS:_____ CITY:_____ STATE:_____ ZIP CODE: _____

E-MAIL:_____ CELL PHONE:_____ HOME PHONE: _____

SS#/SIN:_____ BIRTHDATE: _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

IF COLLEGE STUDENT, F.T/P.T., NAME OF SCHOOL:_____ CITY:_____ STATE:_____

PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER:_____ WORK PHONE: _____

BUSINESS ADDRESS:_____ CITY:_____ STATE:_____ ZIP CODE: _____

SPOUSE OR PARENT'S/GUARDIANS NAME:_____ EMPLOYER:_____ WORK PHONE: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTANCT IN CASE OF AN EMERGENCY:_____ PHONE: _____

LEGAL GUARDIAN (MUST COMPLETE)

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT:_____ RELATIONSHIP TO PATIENT: _____

ADDRESS:_____ HOME PHONE: _____

DRIVER'S LICENSE #:_____ BIRTHDATE:_____ SS#/SSI:_____

EMPLOYER:_____ WORK PHONE: _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED:_____ RELATIONSHIP TO PATIENT: _____

BIRTHDATE:_____ SS#/SIN:_____ DATE EMPLOYED: _____

NAME OF EMPLOYER:_____ UNION OR LOCAL #:_____ WORK PHONE: _____

EMPLOYER ADDRESS:_____ CITY:_____ STATE:_____ ZIP CODE: _____

INSURANCE CO.:_____ TEL. #:_____ GRP #:_____ POLICY/I.D. #: _____

INS. CO. ADDRESS:_____ CITY:_____ STATE:_____ ZIP CODE: _____

HOW MUCH IS YOUR DEDUCTIBLE?_____ HOW MUCH HAVE YOU USED?_____ MAX ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING

NAME OF INSURED:_____ RELATIONSHIP TO PATIENT: _____

BIRTHDATE:_____ SS#/SIN:_____ DATE EMPLOYED: _____

NAME OF EMPLOYER:_____ UNION OR LOCAL #:_____ WORK PHONE: _____

EMPLOYER ADDRESS:_____ CITY:_____ STATE:_____ ZIP CODE: _____

INSURANCE CO.:_____ TEL. #:_____ GRP #:_____ POLICY/I.D. #: _____

INS. CO. ADDRESS:_____ CITY:_____ STATE:_____ ZIP CODE: _____

HOW MUCH IS YOUR DEDUCTIBLE?_____ HOW MUCH HAVE YOU USED?_____ MAX ANNUAL BENEFIT? _____

X_____ _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR PATIENT NUMBER

HEALTH HISTORY

DENTAL ON CENTRAL

PATIENT MEDICAL HISTORY

PATIENT'S NAME:_____ DATE OF BIRTH: _____

Gender: ☐ M ☐ F Are you currently under a physician's care: ☐ YES ☐ NO

Date of last physician visit:_____ Reason:_____

Physician Name:_____ Physician Phone #: _____

Physician Address:_____ City:_____ State:_____ Zip Code: _____

Yes	No	D/K	
☐	☐	☐	Have there been any changes in your general health in the last year?
			Have you had any serious illness, operations, or been hospitalized in the past 5 years?
☐	☐	☐	Reason: _____
☐	☐	☐	Has your physician recommended that you take antibiotics prior to dental treatment:
☐	☐	☐	Have you had an orthopedic total joint replacement? When?: _____
☐	☐	☐	Do you have a heart murmur or a history of rheumatic heart disease?
			Have you taken Pondimin (Fenfluramine), Redux (Dexphenfluramine) or Fen-Phen (Phentermine)?
☐	☐	☐	If "Yes", how long? _____
			Have you taken Fosamax (Alendronate), Actonel (Risedronate), or Bonvia (Ibandronate):
☐	☐	☐	If "Yes", how long? _____
☐	☐	☐	Have you taken cortisone (Steroids) in the last 30 days?
☐	☐	☐	Do you drink any type of alcohol daily? Type/Amount:_____ # of Years:__
☐	☐	☐	Do you use recreational (street) drugs?_____
☐	☐	☐	Have you been treated for chemical or alcohol dependency?_____
☐	☐	☐	Do you use Tobacco? Amount:_____ # of Years:_____

Allergies

Are you allergic to any of the following?

Yes	No	D/K	
☐	☐	☐	Local anesthetic (e.g. Novocaine)
☐	☐	☐	Penicillin/antibiotics
☐	☐	☐	Barbiturates
☐	☐	☐	Sulfa drugs
☐	☐	☐	Codeine or other narcotics
☐	☐	☐	Aspirin
☐	☐	☐	Ibuprofen (Motrin, Advil)
☐	☐	☐	Latex
☐	☐	☐	Nickel (jewelry, clothing snaps)
☐	☐	☐	Acrylic

Type of reaction:_____

Other Allergies:_____

Females Only:

Yes	No	D/K	
☐	☐	☐	Post-menopausal or post-hysterectomy
☐	☐	☐	Are you pregnant? Due date:_____
☐	☐	☐	Are you currently breast feeding?
☐	☐	☐	Are you currently taking birth control medication? Why type? :_____

DENTAL HISTORY

DENTAL ON CENTRAL

Chief Complaint:

Are you receiving routine dental care? ☐ Yes ☐ No
If Yes, Dentist Name: _____
Date of last dental visit: _____
Reason for last dental visit: _____
How often did you visit your previous dentist? _____
Have you had a complete series of dental films (x-rays)
How often do you brush your teeth? _____

Indicate any past major dental treatment (check all that apply)

- ☐ Orthodontics (braces)
- ☐ Oral surgery (extractions)
- ☐ Periodontics (gum treatment or surgery)
- ☐ Endodontics (root canal)
- ☐ Partial dentures
- ☐ Full dentures
- ☐ Crowns
- ☐ Bridges
- ☐ TMJ

How often do you floss your teeth? _____

Have any of the following prevented your from seeking dental care?

- ☐ Fear or anxiety
- ☐ Lack of time
- ☐ Lack of funds/cost
- ☐ No insurance
- ☐ No transportation
- ☐ Other:

Are you satisfied with the appearance of your teeth? ☐ Yes ☐ No

_____

Yes	No	Are your teeth sensitive to:
☐	☐	Sweets
☐	☐	Hot
☐	☐	Cold
☐	☐	Pressure (chewing)

Have you ever had problems/complications with past dental care?
☐ Yes ☐ No
Specify:

Yes	No	Please check all that apply:
☐	☐	Do you have any swelling in your mouth?
☐	☐	Are you teeth shifting?
☐	☐	Are any of your teeth loose?
☐	☐	Do you have any food impaction between teeth?
☐	☐	Are you aware of any loose, broken or missing fillings, or chipped teeth?

Do you drink fluoridated drinking water?
☐ Yes ☐ No ☐ D/K

Dentures
How long worn? _____
Age of present dentures? _____
How many past dentures? _____
Any current problems? _____

Salivary Function

Yes	No	
☐	☐	Does your saliva feel thick or ropey?
☐	☐	Does your mouth feel dry?
☐	☐	Do you have difficulty chewing food?
☐	☐	Do you have difficulty speaking?
☐	☐	Do you have excess saliva?

AUTHORIZATION AND RELEASE
I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____Date:_____
Signature of patient or parent/guardian if minor

Doctor's comments: _____

Doctor Signature:_____ Date: _____

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SYSTEMS REVIEW-CHECK ALL THAT APPLY

Patient Name:_____ Patient DOB: _____

Yes No D/K

☐ ☐ ☐ **1.CARDIOVASCULAR CONDITIONS**
- ☐ Angina
- ☐ Atherosclerosis date: _____
- ☐ Artificial heart valve date: _____
- ☐ Internal defibrillator
- ☐ Heart attack date: _____
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Congenital heart defects
- ☐ Mitral valve prolapse
- ☐ Bypass surgery date: _____
- ☐ Pacemaker date: _____
- ☐ Tire easily
- ☐ Chest pain or shortness of breath

Yes No D/K

☐ ☐ ☐ **2. RESPIRATORY CONDITIONS**
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Chronic bronchitis
- ☐ Asthma
- ☐ Seasonal allergies
- ☐ Sinusitis
- ☐ Tonsil or adenoid conditions

Yes No D/K

☐ ☐ ☐ **3. GASTROINTESTINAL CONDITIONS**
- ☐ Colon disorders
- ☐ Persistent diarrhea
- ☐ Difficulty swallowing
- ☐ Gastroesophageal reflux
- ☐ Ulcers
- ☐ Malnutrition
- ☐ Jaundice
- ☐ Gallbladder trouble/stones
- ☐ Liver disease
- ☐ Hepatitis A B C
- ☐ Cirrhosis
- ☐ Other liver conditions

Yes No D/K

☐ ☐ ☐ **4. ENDOCRINE CONDITIONS**
- ☐ Thyroid problems _____
- ☐ Parathyroid problems _____
- ☐ Diabetes Type: _____
- ☐ Hypoglycemia

Yes No D/K

☐ ☐ ☐ **5. GENITOURINARY CONDITIONS**
- ☐ Kidney problems
- ☐ Dialysis
- ☐ Bladder infections

Yes No D/K

☐ ☐ ☐ **6. SEXUALLY TRANSMITTED DISEASE**

Type: _____

Yes No D/K

☐ ☐ ☐ **7. CANCER**

Site: _____
- ☐ Surgery Date:
- ☐ Chemotherapy Date: _____
- ☐ Radiation therapy Site: _____

Yes No D/K

☐ ☐ ☐ **8. BONE & JOINT CONDITIONS**
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Trauma/Frequent fractures
- ☐ TMJ problems
- ☐ Jaw surgery

Yes NO D/K

☐ ☐ ☐ **9. BLEEDING ABNORMALITIES**
- ☐ Prolonged bleeding
- ☐ Bruise easily
- ☐ Anemia
- ☐ Sickle cell disease _____
  Trait _____
- ☐ Hemophilia Type: _____
- ☐ Blood transfusion Year: _____

Yes No D/K

☐ ☐ ☐ **10. NEUROLOGIC CONDITIONS**
- ☐ Epilepsy
- ☐ Convulsions/seizures
- ☐ Stroke
- ☐ Neuritis
- ☐ Neuralgia/Tics
- ☐ Chronic facial pain
- ☐ Numbness/Paralysis
- ☐ Severe frequent headaches
- ☐ Migraines
- ☐ Repeated blackouts/fainting

Yes No D/K

☐ ☐ ☐ **11. PSYCHOLOGICAL TREATMENT**
- ☐ Depression
- ☐ Anxiety or panic disorders
- ☐ Eating disorders
- ☐ Other psychological disorders

Yes No D/K

☐ ☐ ☐ **12. DERMATOLOGICAL CONDITIONS**
- ☐ Chronic/recurrent skin rash
- ☐ Hives
- ☐ Psoriasis
- ☐ Eczema
- ☐ Other: _____

Yes No D/K

☐ ☐ ☐ **13. IMMUNE CONDITIONS**
- ☐ AIDS or HIV infection
- ☐ Rheumatoid arthritis
- ☐ Immunosuppressive
  - ☐ disease induced
  - ☐ drug induced
  - ☐ induced
- ☐ Specific immune disease: _____

Yes No D/K

☐ ☐ ☐ **14. OTHER**
- ☐ Domestic violence victim
- ☐ Glaucoma
- ☐ Organ/Tissue transplant
- ☐ Night sweats
- ☐ Unintended weight loss
- ☐ Chronic pain Site: _____

DENTAL ON CENTRAL

CURRENT MEDICATIONS
(Including Prescribed, Over-the-Counter, and Herbal or Natural)

Patient Name:_____ Date: _____

Medication	Dose	Reason

DENTAL ON CENTRAL

H.I.P.A.A. ACKNOWLEDGMENT FORM

I have received a copy of the H.I.P.A.A Privacy Act information from Dental on Central, and authorize the following list of people who may receive my Protected Health Information. I understand that I may revoke this authorization at any time by giving written notification to the office.

Name:________________________Date of Birth:_______________Phone Number: _________________________
Relationship to Patient: ☐ Spouse ☐ Child ☐ Parent ☐ Other: ___________________

Name:________________________Date of Birth:_______________Phone Number: _________________________
Relationship to Patient: ☐ Spouse ☐ Child ☐ Parent ☐ Other: ___________________

Name:________________________Date of Birth:_______________Phone Number: _________________________
Relationship to Patient: ☐ Spouse ☐ Child ☐ Parent ☐ Other: ___________________

Name:________________________Date of Birth:_______________Phone Number: _________________________
Relationship to Patient: ☐ Spouse ☐ Child ☐ Parent ☐ Other: ___________________

Name:________________________Date of Birth:_______________Phone Number: _________________________
Relationship to Patient: ☐ Spouse ☐ Child ☐ Parent ☐ Other: ___________________

Name:________________________Date of Birth:_______________Phone Number: _________________________
Relationship to Patient: ☐ Spouse ☐ Child ☐ Parent ☐ Other: ___________________

Name:________________________Date of Birth:_______________Phone Number: _________________________
Relationship to Patient: ☐ Spouse ☐ Child ☐ Parent ☐ Other: ___________________

May we leave messages on your answering machine? ☐ Yes ☐ No

Signed:____ Date:__________________________
(Patient or parent/legal guardian)

DENTAL ON CENTRAL

LEGAL GUARDIAN CONTACT INFORMATION		
First & Last Name:	Relation/Title:	
Address:	City, State:	Zip Code:
Telephone Number:	Cell Phone Number:	

CAREGIVER CONTACT INFORMATION		
First & Last Name:	Relation/Title:	
Address:	City, State:	Zip Code:
Telephone Number:	Cell Phone Number:	

EMERGENCY CONTACT		
First & Last Name:	Relation/Title:	
Address:	City, State:	Zip Code:
Telephone Number:	Cell Phone Number:	
First & Last Name:	Relation/Title:	
Address:	City, State:	Zip Code:
Telephone Number:	Cell Phone Number:	
First & Last Name:	Relation/Title:	
Address:	City, State:	Zip Code:
Telephone Number:	Cell Phone Number:	
First & Last Name:	Relation/Title:	
Address:	City, State:	Zip Code:
Telephone Number:	Cell Phone Number:	