Zakar L. Elloway, DDS
1419 N. Beaver St.
Flagstaff, AZ 86001
(928) 774-4640 Fax: (928) 774-4819

☐ New Patient

Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____
Last, First, MI (preferred name)

Gender: _____ Family Status: S M D W O

Hm #: _____ Cell #: _____

Wk #: _____ Ext: _____

Best place and time to be reached _____

Birthdate: _____ Age: _____

SS#: _____

Mailing Address: _____

_____
City State Zip

Email Address: _____

Employer: _____

Occupation: _____

Responsible Party: _____

Spouse Information

Name: _____

Employer _____

Cell #: _____ Wk #: _____

Emergency Contact

Name: _____ Relationship _____

Ph #: _____ Cell #: _____

Dental Insurance Information

Primary Dental Insurance

Insurance Co Name: _____

Claims Address: _____

_____
City State Zip

Insurance Co Phone #: _____

Group # (plan, local or policy) _____

Payor ID: _____

Insured's Name: _____

Relationship to patient: _____

Insured's Birthdate: _____ SS#: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co Name: _____

Claims Address: _____

_____
City State Zip

Insurance Co Phone #: _____

Group # (plan, local or policy) _____

Payor ID: _____

Insured's Name: _____

Relationship to patient: _____

Insured's Birthdate: _____ SS#: _____

Insured's Employer: _____

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and 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.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such 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. The estimate of what an insurance company will pay is considered a guideline until the final insurance payment is received and the patient's account is reconciled. An insurance policy is a contract between the patient and their insurance company; therefore our office cannot guarantee what an insurance company will eventually pay. To insure you are covered properly, you MUST supply all necessary insurance information to our office prior to your appointment.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied. I also agree that records cannot be released to another doctor/dentist or myself if there is a balance on my account, once it is paid records can be released or transferred.

I understand that the fee estimate listed for this 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, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. 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 attorney fees, court costs, filing fees, including charges or commissions, up to 50%, that may be assessed to me by a collection agency retained to pursue this matter with or without suit. I authorize release of all information necessary to secure payment.

I understand that a minimum 24 hours notice is required for cancellation of appointments. A broken appointment fee may be charged to my account, and is payable by me if 24 hrs notice is not given.

I understand that dentistry is not an exact science and that I may need further treatment if complications arise during or following treatment, the cost of which is my responsibility.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

I HAVE READ THE ABOVE CONDITIONS OF TREATMENT AND PAYMENT AND AGREE TO THEIR CONTENT.

_____ Date: _____ Relationship to Patient:: _____
SIGNATURE OF PATIENT, PARENT or GUARDIAN

Medical History

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

If yes, why? _____

Physician's Name:_____Ph #_____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, why?_____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No

Do you take or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No

Are you taking prescription, diet, herbal or over-the-counter drugs?

(LIST)_____ _____

_____ _____

_____ _____

WOMEN: are you ☐ Pregnant ☐ Nursing ☐ Taking Oral Contraceptives?

Have you had any unusual or allergic reactions to any of the following?

☐ Penicillin	☐ Local Anesthesia	☐ Latex
☐ Erythromycin	☐ Aspirin	☐ Metal
☐ Tetracycline	☐ _____	☐ Acrylic
☐ Codeine	☐ _____	☐ Pollen, etc
☐ Sulfa	☐ _____	

Dental History

Who May we thank for referring you?

_____

☐ Yellow Pages ☐ Internet ☐ Friend/Family ☐ Doctor ☐ Other

Reason for today's visit:_____

_____

Former Dentist: _____

Address:_____Ph#:_____

Date of last dental visit: _____xrays:_____

Were you satisfied with your previous dental care? ☐ Yes ☐ No

Please check if you have problems with any of the following:

☐ Bad Breath	☐ Grinding/Clenching	☐ Sensitivity to cold
☐ Bleeding gums	☐ Loose teeth	☐ Sensitivity to hot
☐ Clicking or popping	☐ Broken fillings	☐ Sensitivity to sweets
☐ Food between teeth	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Orthodontics (braces)	☐ Bad dental experience	☐ Sores or growths

How often do you brush?_____Floss?_____

Are you happy with the color of your teeth? ☐ Yes ☐ No

Have you had any complications following dental treatment? ☐ Yes ☐ No

_____

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV positive	☐ Diabetes	☐ Irregular Heartbeat	☐ Stroke
☐ Alcoholism	☐ Drug Addiction or Habit	☐ Kidney Disease	☐ Surgical Implants
☐ Alzheimers Disease	☐ Epilepsy or Seizures	☐ Leukemia	☐ Swelling of limbs
☐ Anaphylaxis	☐ Emphysema	☐ Liver Disease	☐ Tobacco Habit
☐ Anemia	☐ Endocartisis	☐ Low Blood Pressure	☐ Thyroid Disease
☐ Arthritis or Gout	☐ Excessive Bleeding	☐ Lung Disease	☐ Tonsillitis
☐ Artificial Heart Valve	☐ Fainting/Dizziness	☐ Mitral Valve Prolapse: regurge?__	☐ Tuberculosis
☐ Artificial Joints: Date_____	☐ Frequent Cough	☐ Pain in Jaw Joints	☐ Tumors or Growths
☐ Asthma	☐ Frequent Diarrhea	☐ Psychiatric Care	☐ Ulcers
☐ Back Problems	☐ Frequent Headaches	☐ **Pregnancy**	☐ Venereal Disease
☐ Blood Disease	☐ Glaucoma	Due date:_____	☐ OTHER: _____
☐ Blood Transfusion	☐ Hay Fever	☐ Radiation Treatment	_____
☐ Breathing Problem	☐ Head Injuries	☐ Recent weight loss or gain	
☐ Bruise Easily	☐ Heart Attack yr _____ Stent y/n	☐ Renal Dialysis	
☐ Cancer	☐ Heart Murmur: regurge? _____	☐ Respiratory Problems	
☐ Chemical Dependency	☐ Heart Pacemaker	☐ Rheumatic Fever	
☐ Chemotherapy	☐ Heart Trouble/Disease	☐ Rheumatism	
☐ Chest Pains	☐ Hemophilia	☐ Shingles	
☐ Circulatory Problems	☐ Hepatitis A or B or C	☐ Shortness of Breath	
☐ Cold Sores/Fever Blisters	☐ Herpes: Genital or Other	☐ Sickle Cell Disease	
☐ Congenital Heart Disorder	☐ High Blood Pressure, avg blood pressure _____/_____	☐ Sinus Problems	
☐ Convulsions	☐ Hives or Rash	☐ Spina Bifida	
☐ Cortisone Treatments	☐ Hypoglycemia	☐ Stomach/Intestinal Disease	

FOR OFFICE USE ONLY

☐ PREMEDICATION Required

Rx: _____

☐ NO Premedication Required

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

_____ Date: _____ Relationship to Patient: _____

SIGNATURE OF PATIENT, PARENT or GUARDIAN

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Zakar L Elloway, DDS

10/5/2015

Four Levels of Dental Care

Welcome New Patient, it is our desire to provide you with the highest quality dental care. Our goal is to help you become as healthy as you choose to be. In order to achieve this, we need to understand what your individual dental goals are. Please review the levels of dental care below and choose the one that most closely describes the type of dental care that best suit your needs.

☐ **Level 1• Urgent Care**
People in crisis or with an emergency or accident need immediate help. We see emergencies immediately, whenever possible. This is not the primary focus of our practice however.

☐ **Level 2• Remedial Care**
Patients who choose this level of care desire treatment only when something breaks or becomes uncomfortable. Generally, patients at this level prefer short-term cursory-type examinations, screening for more obvious advanced problems. They usually want to correct immediate problems with as little effort as possible. People at this level are not yet ready for either thorough or preventive treatment.

☐ **Level 3• Maintenance Care**
The people who choose this level of care want to take an active part in the prevention of present and future disease problems, but choose repair solutions that are more short-range in duration. Usually they choose a 2-5 year reparative or corrective treatment, knowing full well that the dental treatment performed today will be repeated again in the near future.

☐ **Level 4• Optimum Care**
Patients at this level are similar to the people described in level 3. They choose to have comprehensive examination and master planning and formulate a long-term treatment plan for health and repair to achieve a future based on choice not chance. Unlike the maintenance care patient, these patients want all treatment to be completed in the most lasting fashion possible. They are happy to take an active role in their achievement of optimal oral health.

_____
SIGNATURE OF PATIENT, PARENT or GUARDIAN