PATIENT INFORMATION

Name:_____
Last First Middle Initial Nickname

D.O.B.:_____ Social Security #:_____ Marital Status: _____ Sex: Male or Female

Address:_____
Street Apt #

City:_____ State:_____ Zip Code:_____

Employment Status:_____ Employer:_____

EmployerAddress:_____
Street City, State Zip

E-mail:_____ Whom may we thank for referring you? _____

PHONE NUMBERS

Home: (_____)_____ Work: (_____)_____ Ext _____ Cell (_____)_____

In Case of Emergency: Name:_____ Phone: (_____)_____

DENTAL INSURANCE INFORMATION

Insurance Company:_____ Group Number:_____

Subscriber Name:_____ Relationship to Patient:_____

Subscriber S.S.# or ID#:_____ Subscriber D.O.B:_____

Subscriber's Employer:_____ Employment Status:_____

Employer Address:_____
Street City, State Zip

Assignment and Release

I certify that I, and/or my dependent(s) have insurance coverage with _____
Name of Insurance Company
and assign directly to **Dr. Michael Recuber** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. Furthermore, I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ X_____
Printed Name of Patient or Guardian Signature of Patient or Guardian

_____ _____
Relationship to Patient Date of Signature

Dental History

Reason for today's visit:_____ How often to you brush? _____ How often do you floss? _____

Date of last exam: _____ Date of last X-rays: _____ Name of Former Dentist: _____

Place a mark on "yes" or "no" to indicate if you currently have or have had any of the following:

☐ Yes ☐ No	Bad breath	☐ Yes ☐ No	Food between teeth	☐ Yes ☐ No	Orthodontic treatment
☐ Yes ☐ No	Bleeding gums	☐ Yes ☐ No	Blisters on mouth/ lips	☐ Yes ☐ No	Pain around ear
☐ Yes ☐ No	Chew on one side	☐ Yes ☐ No	Mouth pain(brushing)	☐ Yes ☐ No	Periodontal treatment
☐ Yes ☐ No	Smoking	☐ Yes ☐ No	Clicking jaw	☐ Yes ☐ No	Sensitivity to cold
☐ Yes ☐ No	Dry mouth	☐ Yes ☐ No	Fingernail biting	☐ Yes ☐ No	Sensitivity to heat
☐ Yes ☐ No	Grinding teeth	☐ Yes ☐ No	Swollen/tender gums	☐ Yes ☐ No	Sensitivity to sweets
☐ Yes ☐ No	Jaw pain/Tiredness	☐ Yes ☐ No	Lip/cheek biting	☐ Yes ☐ No	Sensitivity when biting
☐ Yes ☐ No	Mouth breathing	☐ Yes ☐ No	Burning sensation on tongue	☐ Yes ☐ No	Loose/ broken teeth

Medical History

Physician's Name: _____ Date of your last visit: _____

☐ Yes ☐ No Are you currently taking any medications? List: _____

☐ Yes ☐ No Are you allergic to any medication? List: _____

☐ Yes ☐ No Do you take aspirin? If yes, how often? _____

☐ Yes ☐ No Are you allergic to latex?

☐ Yes ☐ No Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These combinations of lonimin, Adipex, Fastin (brand name for phentermine), Pondimin (fenfluramine) and Redux (desfenfluramine)?"

☐ Yes ☐ No Have you ever taken the following Bisphosphonates to treat Osteoporosis, Bone Density, or Metastatic Bone Cancer: *Fosamax, Actonel, Zometa, Boniva, Aredia, Didronel, Pamidronate I.V., Zolendronate I.V., or Evista*?

Women Only Are you Pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No Do you take birth control pills? ☐ Yes ☐ No
Due Date: _____

Place a mark on "yes" or "no" to indicate if you currently have or have had any of the following:

☐ Yes ☐ No	AIDS/ HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Radiation Treatment
☐ Yes ☐ No	Anemia	☐ Yes ☐ No	Fainting or Dizziness	☐ Yes ☐ No	Respiratory Disease
☐ Yes ☐ No	Arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Rheumatic Fever
☐ Yes ☐ No	Artificial Heart Valve	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Scarlet Fever
☐ Yes ☐ No	Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Shortness of Breath
☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Sinus Trouble
☐ Yes ☐ No	Back Problems	☐ Yes ☐ No	Hepatitis, Type_____	☐ Yes ☐ No	Skin Rash
☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Special Diet
☐ Yes ☐ No	Blood Disease	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Stroke
☐ Yes ☐ No	Cancer	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen Feet / Ankles
☐ Yes ☐ No	Chemical Dependency	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Swollen Neck Glands
☐ Yes ☐ No	Chemotherapy	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Thyroid Problems
☐ Yes ☐ No	Circulatory Problems	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tonsillitis
☐ Yes ☐ No	Congenital Heart Lesions	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tuberculosis
☐ Yes ☐ No	Cortisone Treatments	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Tumor on Head / Neck
☐ Yes ☐ No	Cough(Persistent / Bloody)	☐ Yes ☐ No	Nervous Disorder	☐ Yes ☐ No	Ulcer
☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Venereal Disease
☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Weight Loss (sudden)

I certify that the above statements about my medical history are accurate. I authorize and give consent for my dentist to perform dental services agreed upon; including the use of local anesthesia as necessary for treatment.

X_____/_____ _____

Signature of Patient/Guardian Date Signature of Dentist

Special Note To New Patients:

A professional cleaning performed by a dental hygienist or a dentist is a medical procedure, and must be prescribed by a qualified health care practitioner. In some cases, dental conditions exist that have to be addressed before a cleaning is possible. In these circumstances other types of treatment may be required first, in order to best provide for the health of the patient.

Because of this, legally and ethically, an examination and x – rays as required by the dentist must be done before a cleaning can be given. After an exam and x –rays have been done; the doctor will be able to see whether or not a cleaning is needed as the next step, or if a different procedure is required first.

Dr. Recuber and his staff are committed to helping their patients achieve and maintain healthy teeth and gums for the long term. The procedures we follow are in the interest of achieving this for as many of our patients as possible.

I have read the above statement, I have been given the opportunity to ask questions about it, and I understand it.

Signed_____Date_____

In the event that you need dental treatment, is there another person (e.g. spouse, parent, etc.) who is involved in decisions regarding your healthcare and/or your financial decisions? Yes____No____

If yes, please give their name relationship to you:_____

Financial Policy

As a professional courtesy to our patients, we make every effort to inform you about the cost of your dental care prior to your treatment. Despite our best efforts, we cannot always anticipate every cost, or how much your insurance plan will reimburse. In order to diminish unforeseen expenses, we ask that you, too, become informed about your insurance coverage. Together, we can achieve better results.

Payment is expected on the day that dental services are rendered. If you have dental insurance, we will be happy to submit your claim on your behalf. If your coverage can be verified, then we will collect any deductibles, co-payments, or co-insurance on the day of service and bill your insurance company for the remaining balance. In the event that your coverage cannot be verified prior to your treatment, we will collect payment in full at the time of your service, and provide you with the forms to submit to your insurance company for reimbursement. *Please note that reimbursement from your insurance company is not guaranteed; any unpaid claims are the patient's / guarantor's responsibility.*

Cancellation Policy

We understand that occasionally unplanned events require you to break an appointment with us. When this happens please extend to us the courtesy of at least 24 hours advance notice. We will be happy to reschedule your appointment to a more convenient time. Failure to notify the office could result in a **$45 fee per hour** of scheduled time.

I have read and accept the terms of the financial and cancellation policies. I further agree to pay all collection costs, and/or attorney fees that may be incurred to enforce the collection of any amount outstanding.

Signature_____ Date_____

*For your convenience, we accept payment by cash, debit cards, personal checks, MasterCard, Visa, Discover and American Express.

michael Recuber D.D.S., P.C.
family + cosmetic dentistry

Because we are committed to providing the best in dental care, our office has chosen not to use amalgam (silver) fillings, in most circumstances. Amalgam fillings require the destruction of larger amounts of healthy tooth than necessary. This, in turn, can lead to cracking of the tooth and the possibility of needing a crown.

Instead, we choose to use resin (tooth-colored) fillings. In addition to being more aesthetically pleasing, resins (also called composites) are bonded to the tooth. This allows the dentist to remove **only unhealthy** tooth structure.

Unfortunately, most insurance companies will only reimburse for amalgam fillings, leaving the patient to pay the difference. Most of the time this amount is very minimal, and well worth the additional cost.

We thank you for choosing our office for your dental care, and we strive to make your experience a pleasant one.

I have read and I understand the above policy. If my insurance company does not reimburse for resin fillings, I agree to compensate the dentist for the difference.

Signature _____ Date _____

Print Name _____

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Michael Recuber, D.D.S., P.C.
8877 W. Union Hills Dr., Bld. E, Suite 500
Peoria, Arizona 85382

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse To Sign This Acknowledgement

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

_____
Please Print Name

X _____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice Of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please specify)

_____

_____

_____