Medical History Date_____

Arizona Dental Management

Patient information Full Name(Print) _____ Date of Birth _____/_____/_____

Address_____ City_____ State_____ Zip_____

Home Phone(____)_____-_____ Cell Phone (____)_____-_____ Marital Status _____

SSN _____-_____-_____ Sex _____ Height _____ Weight _____

Occupation/Employer_____ Position_____ Work Phone _____

Part Time __ Full time __ ***Full time college students using their parents coverage may need to provide proof of full time student status***

Email_____

Emergency Contact Name_____ Relationship to Patient _____

Home Phone_____ Cell phone_____

**How did you hear about us? [ ] Friend/Relative_____ [ ] Insurance_____ [ ]Other _____

Responsible Party(Guarantor): Relationship to Patient_____

Name_____ DOB_____ Sex_____

Address_____City_____State_____Zip_____

Home Phone (____)_____-_____ Work/Cell Phone (____)_____-_____ SSN_____-_____-_____

Email_____

Occupation/Employer_____ Position_____ Work Phone_____

Primary Dental Insurance:

Subscriber's name_____ DOB_____ Relationship to Patient_____

Employer_____ Insurance Company _____

Policy ID# or SSN_____

Secondary Dental Insurance:

Subscriber's name_____ DOB_____ Relationship to Patient_____

Employer_____ Insurance Company _____

Policy ID# or SSN_____

Primary Physician's Name_____ Phone Number (_____)_____-_____

Date of last physical exam _____ Are you now under a physician's care for a particular problem? Yes [ ] No [ ]

If yes, please explain._____

Emergency Contact Name_____ Relationship to Patient _____

Home Phone_____ Cell phone_____

Pharmacy Name, Cross Streets & Phone Number:_____ (_____)_____-_____

I request all benefits, if any, or other amounts otherwise payable to meor on my behalf for services rendered, be paid directly to the provider of services. I understand that I am financially responsible for all charges of services performed by the provider. If the insurance proceeds are insufficient to cover my obligations for service rendered, I am liable for the shortfall. I authorize the provider of services to release all information necessary to secure the payment for services rendered. Failure to provide complete information may result in receiving a bill for services rendered. I am aware that by signing below I certify that all the information is complete and correct to the best of my knowledge.

Print Name _____ Patient Signature _____ Date _____

Parent/ Guardian _____