Reem Kidess, D.D.S., P.L.L.C.
7125 E. Lincoln Dr., Suite A-105, Paradise Valley, AZ 85253
www.PVsmiles.com

Patient Information

Patient Name: ____________________ ________ ________ Date: ________
Last First MI Title **(Preferred Name)**

Gender: _______ Family Status: __________ Occupation: ______________ Birth Date: __________

Address: ____
Street Apartment #

____
City State Zip Code

Phone (Home): __________ (Work): __________ (Cell): __________ Best place to call: _______

Email Address: ______________________

What is your preferred method of contact: ____________________

Health Information

Date of Last Dental Visit: ____________________ Reason for this visit: ____________________

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

- ☐ AIDS
- ☐ Allergies__________
  - ☐ Penicillin Allergy
  - ☐ Codeine Allergy
  - ☐ Sulfa Allergy
  - ☐ Latex Allergy
  - ☐ Any other Allergy__________
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Thinners / Coumadin Therapy
- ☐ Cancer
  - ☐ Radiation Treatment
  - ☐ Chemotherapy

When was your last treatment________

- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Currently Pregnant
  Due Date:
- ☐ Currently trying to get pregnant
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

OTHER:
- ☐ ____________________

• Please list ALL Medications you are taking, prescription and over the counter, please include dosage information:

____
____
____
____

• Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: ____

• Have you been admitted to a hospital or needed emergency care during the past years? ☐ Yes ☐ No
If yes, please explain: ____

• Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: ____

• Name of Physician: ______________________ Phone: ______________

• Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: ____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date: ____________
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend, relative

☐ Another Dr's Office ☐ Search Engine/Website ☐ Yellow Pages ☐ Lumineers ☐ 1-800-Dentist ☐ Other

Name of person or office referring you to our practice: ______________________________

Responsible Party Information

The following is for: ☐ the person responsible for payment (if not the patient)

Name: ______________________________

☐ Male ☐ Female

Relationship to patient: ______________________________

Birth Date: ______________________________

Phone (Home): ____________ (Work): ____________ (Cell): ____________ Best place to call: ____________

Email Address: ______________________________

Address: ______________________________

Street Apartment #

____

City State Zip Code

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.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

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 costs and reasonable attorney fees if suit be instituted hereunder.

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 read the above conditions of treatment and payment and agree to their content.

______________________________ Date: ____________ Relationship to Patient: ____________

Signature of patient, parent or guardian

______________________________ Date: ____________ Relationship to Patient: ____________

Signature of guarantor of payment/responsible party