1840 N Craycroft Rd.
Tucson, AZ, 85712
Phone: (520) 886-2822
Fax: (520) 886-2229
www.shariridds.com

CRAYCROFT DENTAL CARE

Sonia Hariri, DDS,
Stephanie Hartung, DDS

PATIENT REGISTRATION

Section 1 of 5

PLEASE COMPLETE THE CONFIDENTIAL INFORMATION IN ALL THE SECTIONS

GETTING TO KNOW YOU, THE PATIENT

Date:

Last Name:
M.I.
First Name :
Prefers to be Called by:

Address:
City:
State/Province:
Zip/Postal Code:

Home Phone NO.
Work Phone NO.
Cell Phone NO.
Email Address:
Social Security NO.
Birthdate:
Age:

◯ Male ◯ Female

Occupation:
Employer's Name:

Student Status: ◯ NO ◯ FT ◯ PT
School Name:

◯ Married ◯ Single ◯ Divorced ◯ Widowed

Spouse Name:
Phone NO.

PERSON TO CONTACT IN CASE OF AN EMERGENCY

Name
Relationship to Patient
Phone NO.
Address
City State Zip

DENTAL INSURANCE

Primary Carrier

Insurance Company
Group NO.
Employer Name
Employer Address
Policy Holder's Name
Date Of Birth
Relationship to Patient
Incurance I.D NO.
Policy Holder's SSN.

Secondary Carrier

Insurance Company
Group NO.
Employer Name
Employer Address
Policy Holder's Name
Date Of Birth
Relationship to Patient
Incurance I.D NO.
Policy Holder's SSN.

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBILITY FOR ACCOUNT
(IF DIFFERENT FROM PATIENT ABOVE)

Name
Relationship to Patient
Address
City State Zip
Phone NO. SSN

HOW DID YOU HEAR ABOUT US:

☐ Social Media ☐ Website ☐ Referral

Other

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a through diagnosis of patient's dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor or designated staff to disclose of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. If I have dental insurance I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Craycroft Dental Care.

6. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 3% interest may be added to my account. If required, I also understand a check of my credit history may be made.

7. In the event that it becomes necessary to place the account with a collection agency to collect the balance due, an additional 35% of the principle balance due will be added to help defray the cost of collection. In addition, should legal action become necessary to collect the balance due, I understand that I will be responsible for reasonable attorney's fees, interest and court costs. Should the account be placed with a collection agency or attorney I understand that a credit report may be pulled for the sole purpose of collecting the delinquent balance.

☐ **Check this box to confirms that I have read and understand the above statements.**

Patient Name

Dependent family members also covered by this acknowledgement:

Relationship to Patient

Patient/Guardian Signature _____ **Date** _____

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CRAYCROFT DENTAL CARE

Sonia Hariri, DDS,
Stephanie Hartung, DDS

MEDICAL HISTORY - New Patient

Section 2 of 5

Patient Name _____

For Office Use Only — **Patient Blood Pressure:** **Medical Alert:**

1- Have you been under the care of a physician for any medical condition in the last two years? ◯ YES ◯ NO

If YES, please Describe _____

2- Date of your last medical exam: _____

3- Physician (PCP) Name: _____ Phone Number: _____

4- Have you been a patient in the hospital during the past five years? ◯ YES ◯ NO

5- Are you currently taking any prescription medication, drugs, pills, herbal remedies, or over-the-counter medications? ◯ YES ◯ NO

If YES, please list: _____

6- Have you ever taken **bone loss prevention drugs such as Fosamax, Boniva**, or another similar drug? ◯ YES ◯ NO

7- Are you aware of having an **allergic or adverse reaction** to any substance or medication? ◯ YES ◯ NO

If YES, please list: _____

8- Have you ever taken, or are you currently using recreational or street drugs? ◯ YES ◯ NO

If YES, explain: _____

9- Indicate which of the following you currently have or have had in the past. Select "Yes" or "No" for each item:

Heart Surgery, Disease, or Attack	◯ YES	◯ NO	Kidney Trouble	◯ YES	◯ NO	Hepatitis ◯ A ◯ B ◯ C	◯ YES	◯ NO
Chest Pain or Angina	◯ YES	◯ NO	Ulcers	◯ YES	◯ NO	Venereal Disease	◯ YES	◯ NO
Congenital Heart Disease	◯ YES	◯ NO	Diabetes (Hemo, A1C)	◯ YES	◯ NO	HIV/AIDS	◯ YES	◯ NO
Heart Murmur	◯ YES	◯ NO	Thyroid Problems	◯ YES	◯ NO	Cold Sores/Fever Blisters	◯ YES	◯ NO
High Blood Pressure	◯ YES	◯ NO	Glaucoma	◯ YES	◯ NO	Blood Transfusion	◯ YES	◯ NO
Low Blood Pressure	◯ YES	◯ NO	Contact Lenses	◯ YES	◯ NO	Hemophilia	◯ YES	◯ NO
Mitral Valve Prolapse	◯ YES	◯ NO	Emphysema or COPD	◯ YES	◯ NO	Sickle Cell Disease	◯ YES	◯ NO
Artificial Heart Valve/Pacemaker	◯ YES	◯ NO	Chronic Cough	◯ YES	◯ NO	Bruise Easily	◯ YES	◯ NO
Rheumatic Fever	◯ YES	◯ NO	Tuberculosis	◯ YES	◯ NO	Liver Disease/Jaundice	◯ YES	◯ NO
Arthritis/Rheumatism	◯ YES	◯ NO	Asthma	◯ YES	◯ NO	Neurological Disorders	◯ YES	◯ NO
Cortisone Medicine	◯ YES	◯ NO	Hay Fever/Allergies/Hives	◯ YES	◯ NO	Epilepsy or Seizures	◯ YES	◯ NO
Swollen Ankles	◯ YES	◯ NO	Sinus Trouble	◯ YES	◯ NO	Fainting or Dizzy Spells	◯ YES	◯ NO
Stroke	◯ YES	◯ NO	Radiation Therapy	◯ YES	◯ NO	Psychiatric Care	◯ YES	◯ NO
Diet: Special/Restricted	◯ YES	◯ NO	Chemotherapy	◯ YES	◯ NO	Taking Antidepressants	◯ YES	◯ NO
Artificial Joints (hip, knee, etc.)	◯ YES	◯ NO	Tumors/Cancer	◯ YES	◯ NO	Latex Sensitivity	◯ YES	◯ NO

10- Have you had any radiation treatment to the head and neck? ◯ YES ◯ NO

If YES, please indicate:

11- Do you have, or have you had any disease, condition, or problem not listed? ◯ YES ◯ NO

If YES, please list:

12- Have you ever taken prescription medications for weight loss (diet pills)? ◯ YES ◯ NO

If YES, did you take any of the following? ☐ Fen-Phen ☐ Pondimen ☐ Redux ☐ Other

If YES to any of the above, did you have a medical exam for heart issues? ◯ YES ◯ NO

If YES, please explain:

13- Have you unintentionally lost or gained more than 10 pounds in the last year? ◯ YES ◯ NO

14- WOMEN: Are you pregnant, trying to get pregnant, or think you could be pregnant? ◯ YES ____ Months ◯ NO

Are you nursing? ◯ YES ◯ NO

Do you use birth control prescriptions? ◯ YES ◯ NO

Patient Name

Relationship to Patient

Patient/Guardian Signature _____ **Date** _____

For Office Use Only:

Doctor Signature _____ **Date** _____

Please Complete Next Section

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CRAYCROFT DENTAL CARE

DENTAL HISTORY

Section 3 of 5

Sonia Hariri, DDS,
Stephanie Hartung, DDS

Patient Name

What is the reason for your visit today?

Date of Last Dental Visit: **Last Dental Cleaning:** **Last Full Mouth X-rays:**

What was done at your last dental visit?

Previous Dentist's Name: Address:

City: State: Zip: Telephone:

Have you ever been told to take a pre-medication, such as an antibiotic, prior to dental treatment? ◯ YES ◯ NO

Have you ever had an upsetting dental experience? ◯ YES ◯ NO

If YES, please describe:

How often do you have dental examinations?

How often do you brush your teeth? **Floss?**

Have you used or are currently using topical Flouride? ◯ YES ◯ NO

What other dental aids do you use? (interplak, toothpick, etc.)

Do you have any dental problems now? ◯ YES ◯ NO

If YES, please describe:

Are you interested in fixing any dental problems you may have? ◯ YES ◯ NO

What would prevent you from taking care of these problems?

Are any of your teeth sensitive to:

Hot or Cold? ◯ YES ◯ NO **Sweets?** ◯ YES ◯ NO **Biting or Chewing?** ◯ YES ◯ NO

Have you noticed any mouth odors or bad taste? ◯ YES ◯ NO

Do you frequently get cold sores, blisters or any other oral lesions? ◯ YES ◯ NO

Do your gums bleed or hurt? ◯ YES ◯ NO

Have your parents experienced gum disease or tooth loss? ◯ YES ◯ NO

Have you noticed any loose teeth or change in your bite? ◯ YES ◯ NO

Does food collect between your teeth? ◯ YES ◯ NO

If YES, please describe:

Do you:

Bite your lips or cheeks regularly? ◯ YES ◯ NO

Experience dry mouth? ◯ YES ◯ NO

Hold foreign objects with your teeth? (pencils, a pipe, pins, nails, fingernails) ◯ YES ◯ NO

Currently or formerly smoke/chew tobacco or use other tobacco products? ◯ YES ◯ NO

Have you ever had:

Dentures (U / L) or Partials (U / L) ◯ YES ◯ NO

If YES, Indicate DATE:

Oral Surgery/Wisdom teeth removed? ◯ YES ◯ NO

Periodontal (Gum) Treatment? ◯ YES ◯ NO

If YES, Indicate DATE:

Orthodontics (Braces), active or past? ◯ YES ◯ NO

Your teeth ground or your bite adjusted? ◯ YES ◯ NO

A bite plate or mouth guard? ◯ YES ◯ NO

A serious injury to the mouth or head? ◯ YES ◯ NO

If YES, please describe:

Have you experienced:

Clenching or grinding your teeth while awake or asleep? ◯ YES ◯ NO

Clicking or popping of the jaw? ◯ YES ◯ NO

Pain in the joint, ear, or sore facial muscles? ◯ YES ◯ NO

Difficulty in opening or closing your mouth? ◯ YES ◯ NO

Difficulty chewing on either side of mouth? ◯ YES ◯ NO

Tired jaws, especially in the morning? ◯ YES ◯ NO

Headaches, neck aches or shoulder aches? ◯ YES ◯ NO

Snoring? ◯ YES ◯ NO

Using a C-PAP? ◯ YES ◯ NO

If there anything else about having dental treatment that you would like us to know?

Do you feel nervous about having dental treatment? ◯ YES ◯ NO

If so, what is your biggest concern?

Which of the following would you like to discuss with the dentist? (Please circle all that apply)

☐ Crowded or Crooked Teeth ☐ Discolored Teeth or Crowns ☐ Spaces

☐ Tooth Shape or Size ☐ Missing Teeth ☐ Under or Over bite

☐ Gummy Smile ☐ None Other

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CRAYCROFT DENTAL CARE

Financial Information

Section 4 of 5

Sonia Hariri, DDS,
Stephanie Hartung, DDS

We pride ourselves on providing the highest quality dental care available. In order for us to do this on a sound business basis, we have several options in place to assist us in planning your treatment, and to make your care affordable. By establishing a clearly defined outline of cost with regard to your treatment process, we can proceed and complete your care in a very timely manner.

Dental Insurance:

For patients with dental insurance, we are happy to file claims to most private PPO and indemnity insurance companies for you, and will directly bill them for reimbursement for your treatment. Your co-pay, percentage, and/or deductible are due at the time of service. We always do our best to estimate insurance benefits for you, and we will do everything we can to help you maximize the benefits to which you are entitled. However, it is your responsibility to know your plan benefits, maximums, and limitations. Our responsibility is to you, the patient, and your health, not your insurance. Any treatment estimates given are not a guarantee of payment.

If treatment is recommended at your exam, you will be given the opportunity to have any of your questions or concerns addressed. You will also be given a copy of your treatment plan for your review, which lists the procedure(s) and code(s). We encourage you to review these prior to your next appointment. Our treatment plans are designed specifically for you, based on your oral conditions and the best possible treatment options, not based on what insurance covers.

No Insurance:

No dental insurance? No problem. We understand that your oral health and that of your family comes first, no matter what your situation. Whether you have lost insurance due to a change in employment status or effects of the economy, or whether it is not available to you, we are here to help. Our office is proud to offer a variety of unique payment options to complete your treatment goals.

Payment Options:

Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

a) Cash or Check are always welcome*****
b) Credit/Debit Cards accepted: Visa, Mastercard, American Express, Discover
c) Convenient Monthly Payments through CareCredit Healthcare Credit Card (OAC) [No-interest and low-interest options available]

***Please note that Craycroft Dental Care charges $25 for returned checks, and ID is required.**

Referrals:

Sometimes a referral to a dental or medical specialist is necessary. If a referral is needed, we will send you to a provider that will give you the best possible care. If you choose to see a specialist within your dental insurance network, different from the referral given, it is your responsibility to locate a provider and notify us of your choice. Please keep in mind that our specialists of choice are made for your best dental outcome.

Appointment Protocol:

We value you as a patient and will make every effort to make your appointment as comfortable as possible. Our goal is for you to enjoy and maintain a healthy smile. When an appointment is scheduled, that time is reserved especially for you. In the event that you are unable to keep your appointment, we require at least a 48-hour notice, otherwise a missed-appointment fee of $25.00 will be assessed.

Mission Statement:

Our unique patients deserve unrivaled superior dental services. We take pride in our dedication to continuous proven developments in state-of-the-art dental innovations. Our patients value our services through their involvement in treatment decisions and commitment to continuing care in their quest for long-term oral health. Your smile makes our day.

☐ **Check this box to confirms that I have read and understand the above statements.**

Patient Name _____

Patient/Guardian Signature _____ **Date** _____

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CRAYCROFT DENTAL CARE

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Section 5 of 5

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that! may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations.

Patient Name

Dependent family members also covered by this acknowledgement:

Relationship to Patient

Patient/Guardian Signature **Date**

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- ◯ The patient refused to sign
- ◯ Communication barriers
- ◯ Emergency situation
- ◯ Other

Notice:

Please download the form and fill it out then submit via Email or print it.

Print Form Submit by Email