Welcome

Thank you for selecting our dental health care team! We will strive to provide you with the best possible dental care. To help us meet all of your dental health care needs, please fill out this form ***completely*** *in ink. If you need any assistance or have any questions, we will be happy to help!*

Date:

Patient Information

Patient Name:_____ Date of Birth:_____/_____/_____

Address:_____ Social Security #:_____-_____-_____

City:_____ State:_____ Zip:_____ Driver's License #:_____

Home Phone:_____ Work Phone: _____ Cell Phone: _____

Email Address:_____

Who may we thank for referring you?_____

Please Circle:
Single Married
Child Other

Responsible Party Information Relation: Self Parent/Guardian Other:_____

Full Name:_____ Date of Birth:_____/_____/_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Social Security #:_____-_____-_____ Driver's License #:_____

Emergency Contact Information

Full Name:_____ Relation:_____

Primary Phone:_____ Secondary Phone:_____

Insurance Information Do you have dental insurance?: YES NO If yes, please fill in below:

Policy Holder:_____Self/Parent/Guardian/Other D.O.B:_____/_____/_____

Insurance Name:_____ Subscriber ID#/SS#:_____

Group/Employer Name:_____ Group #:_____

Do you have a secondary dental insurance? YES NO If yes, please fill in below:

Policy Holder:_____Self/Parent/Guardian/Other D.O.B:_____/_____/_____

Insurance Name:_____ Subscriber ID#/SS#:_____

Group/Employer Name:_____ Group #:_____

Patient/Guardian Signature:_____ **Date**_____

Medical History

Do you have any dental concerns at this time?_____

Please check if you have or have had any of the following: *DO NOT leave anything blank*

AIDS/HIV	☐ Yes	☐ No	Endocarditis	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Fainting/Dizziness	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Joints*See below	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Smoking	☐ Yes	☐ No
Bleeding Abnormally	☐ Yes	☐ No	Hepatitis Type _____	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Blood Thinners	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	T.M.J. Dysfunction	☐ 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	Tumors/Growths on Head	☐ Yes	☐ No
Cough, Persistent or Bloody	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Weight Loss, Unexplained	☐ Yes	☐ No

Medications

_____

_____

_____

_____

Pharmacy Name:_____

Pharmacy #:_____

Allergies

Please circle **YES** or **NO**

Aspirin Codeine Penicillin

Barbiturates (Sleeping Aids) Sulfa

Local Anesthetic Iodine Latex

Other_____

Female Patients Only

Are you pregnant? ☐ YES ☐ NO

Are you nursing? ☐ YES ☐ NO

Are you on birth control? ☐ YES ☐ NO

***Artificial Joints**: Type of joint(s) replaced:_____ Surgery Date:_____

Did you pre-medicate for today's appointment? ☐Yes ☐ No If no, do you have clearance? _____

Please detail any specific pre-medication (prophylactic antibiotic) instructions your doctor/surgeon has given you most recently:_____

Please list any other medical concerns not listed on this form:_____

_____

We confirm all appointments by phone call, text, & email. Please let us know if you have a confirmation preference:

Please take note of Cancellation Policy on next page.

Notes:_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Patient/Guardian Signature:_____ **Date**_____

Gabriel T. Woodruff, D.M.D., P.L.L.C.
6500 N Scottsdale Road, Suite B-200
Scottsdale, AZ 85253
(480)946-6503

►►►OFFICE POLICIES◄◄◄

We appreciate your selection of our office to serve your dental health needs. Our goal is to provide the very best possible dental care for our patients so that each of you may achieve optimal dental health throughout your lifetime. Our entire staff operates as a team and we take great pride in each staff member's training and capabilities.

Please initial at each section indicating that you've read and understand our office policies.

Initials

OFFICE HOURS

Monday: 7:00am – 5:00pm (Lunch 12:00pm – 1:00pm)
Tuesday: 7:00am – 5:00pm (Lunch 12:00pm – 1:00pm)
Wednesday: 8:00am – 5:00pm (Lunch 12:00pm – 1:00pm)
Thursday: 7:00am – 5:00pm (Lunch 12:00pm – 1:00pm)
Friday: Closed
Weekends: Closed

*The practice is closed on major holidays as well as times when Dr. Woodruff and staff are attending Continuing Education courses to keep abreast of the latest developments.

Initials

PAYMENT POLICY

In an effort to keep dental costs down, while maintaining a high level of professional care, ***payment is due at time or before services are rendered.*** We accept all major credit cards as well as personal checks and cash. Please note, we do not keep change in the office for cash paying customers. If you need any other payment options, please make arrangements in advance.

Initials

CANCELLATION POLICY

All appointments made in our office are reserved for each patient to see the Dentist or Hygienist so that we may meet the needs of each of our patients. Broken appointments result in a loss of valuable time that could be spent with patients in need of treatment and they are very costly to our office. Please make every effort to keep your scheduled appointment. As a courtesy, we will make reminder calls for each appointment.

$45.00 Charge: 1 hour Hygiene appointments require 24 business hours to cancel or reschedule.
$100.00 Charge: 2 hour Hygiene appointments require 48 business hours to cancel or reschedule.
$100.00 Charge: Dr. Woodruff appointments require 48 business hours to cancel or reschedule.
***Please note:** Multiple family members scheduled in the same day require 48 business hours notice.
**Our practice is closed on Fridays. Fridays are not considered business hours.

Initials

INSURANCE

We will be happy to file insurance claims for our patients with dental insurance with adequate information provided. However, our professional services are rendered and charged to the patient, not to the insurance company. If in the event an insurance company denies a claim, the balance is the patient's/responsible party's responsibility. Our office cannot accept responsibility for collecting or negotiating a settlement on a disputed claim. Any outstanding balances will be sent by Statement to the patient monthly.

PATIENT/GUARDIAN SIGNATURE:_____ **DATE:**_____

Woodruff Dental PLLC
Gabriel T. Woodruff, D.M.D.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Patient Name:_____ Patient Date of Birth:_____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting

Contact Person: _____Chelsea L. Foley, Office Manager & HIPAA Officer_____

Telephone:_____(480)946-6503_____ Fax:____(480)945-8248_____

Address:_____6500 N Scottsdale Rd., Suite B-200_____ Email:___dr.woodruff.dentistry@gmail.com___

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SECTION C: CONSENT FOR DISCLOSURE TO OTHER PARTIES

If you would like to give authorization to a third party not otherwise included in Section B, please list them here:

Name:_____ Phone:_____ Relation:_____

Address:_____ Email Address:_____

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____ Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____

Relationship to Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.