Welcome

Thank you for selecting our dental heath 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!

Patient Information Date:_____

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

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

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

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

Email:_____ Please circle: Married Single Child Other

Who may we thank for referring you?_____

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

Dental Insurance: ☐ Yes ☐ No If yes, please fill out the information below:

Policy Holder:_____ Self/Parent/Guardian/Other Birthdate:_____/_____/_____

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

Group/Employer Name:_____ Group#:_____

Do you have a secondary insurance? ☐ Yes ☐ No If yes, please fill out information below:

Policy Holder:_____ Birthdate:_____/_____/_____

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

Group/Employer Name:_____ Group#:_____

MEDICAL HISTORY

Do you have any dental concerns at this time?_____

Please check if you have or ever have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or Dizziness	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Arthritis,Rheumatism	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Smoking	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis Type _____	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Bleeding Abnormally			Herpes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
with Extractions or Surgery	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	T.M.J. Disfuction	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Tumor or Growth on Head		
Cortisone Treatments	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	or Neck	☐ Yes	☐ No
Cough, Persistent or Bloody	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No	Weight Loss, Unexplained	☐ Yes	☐ No

If you are female, are you: Pregnant? Yes or No Nursing? Yes or No Birth Control? Yes or No

MEDICATIONS

_____

_____

_____

_____

Pharmacy Name:_____

Pharmacy Number:_____

ALLERGIES Please Circle

Aspirin	**Local Anesthetic**
Barbiturates (Sleeping Pills)	**Penicillin**
Codeine	**Sulfa**
Iodine	**Latex**

Other_____

_____

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

_____

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.
7600 E. Camelback Road, Suite #9
Scottsdale, AZ 85251
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.

OFFICE HOURS

Monday: 7:00am – 5:00pm (Lunch 12:00pm – 1:00pm)
Tuesday: 7:00am – 5:00pm (Lunch 12:00pm – 1:00pm)
Wednesday: 7:00am – 5:00pm (Lunch 12:00pm – 1:00pm)
Thursday: 8:00am – 2:00pm
Friday: Closed

The office 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.

PAYMENT POLICY

In an effort to keep dental costs down, while maintaining a high level of professional care, we have established the following policies for our patient's use.

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.

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.

24 hour notice is required to cancel or reschedule your dental appointment.

48 hour notice is required to cancel or reschedule major dental treatment or multiple family members scheduled on the same day.

There is a $45.00 charge for each broken appointment.

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/Responsible Party Signature:_____

Date:_____

Woodruff Dentistry
Gabriel T. Woodruff D.M.D.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:_____

Address:_____ Social Security:_____

_____ Email:_____

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. Wilkins, Office Manager & HIPAA Officer_____

Telephone:_____480-946-6503_____ Fax:___480-945-8248_____

Address:_____7600 East Camelback Road, Suite 9_____Email:__dr.woodruff.dentistry@gmail.com__

_____Scottsdale, Arizona 85251_____

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.

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.