AristidisPontikas, D.M.D., M.S.,P.L.L.C.
Medical/Dental History

Name: First, Middle, Last	Sex	Birth Date	Marital Status	Email Address
Street Address	City	State	Zip	
Social Security Number	Cell Phone			
Home Phone	Daytime/Work Phone/ext	Employer's Name & Address		
Person Responsible For Payment of Account	Relation	Phone H) W)		
Dentist's Name, Phone Number, Address	Referred to This Office By:			
In Case of Emergency Contact- Name and Phone Number	Preferred Hospital			

Primary Dental Insurance Company	Subscriber's ID or Social Security Number
Subscriber's Name	Subscriber's DOB	Group or Company Name
Group Number	Patient's Relationship to Subscriber- self* spouse* child
Secondary Dental Insurance Company	Subscriber's ID or Social Security Number
Subscriber's Name	Group or Company Name
Group Number	Patient's Relationship to Subscriber- self* spouse* child

Medical Doctor's Name	Phone #	Fax #
Medical Doctor's Address		
My Last Physical Examination was on (Date)	Results	
Are you under the care of your physician? If Yes, for what reason?		

Are you taking any medication at the present time (including Aspirin or Coumadin or Birth Control Pills)- **PLEASE LIST THEM HERE:**
Are you sensitive or allergic to any medication? If yes, list reasons and dates:
Have you ever been hospitalized, had any surgical operations, or blood transfusions? If Yes, list reasons and dates:
Have you ever had implants, transplants, or joint replacements? If yes When?
Are you now, or have you ever taken medication for osteoporosis? If yes, which one and for how long?

Do you currently or have you had:

☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No Low Blood Pressure
☐ Yes ☐ No Psychiatric Treatment
☐ Yes ☐No Cancer_____
☐ Yes ☐No Chemotherapy
☐ Yes ☐ No Radiation Treatment
☐ Yes ☐ No Multiple Sclerosis
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Scarlet Fever
☐ Yes ☐ No Heart Murmur
☐ Yes ☐ No Heart Disease
☐ Yes ☐ No Gall Bladder Disease
☐ Yes ☐ No Joint replacement
☐ Yes ☐ No Smoking/Tobacco use
☐ Yes ☐ No Mitral Valve Prolapse
☐ Yes ☐ No Stroke- Date_____
☐ Yes ☐ No Thyroid Disease_____
☐ Yes ☐ No Angina Pectoris
☐ Yes ☐ No Fainting or Dizzy Spells
☐ Yes ☐ No Kidney Disease

☐ Yes ☐ No Allergies or Hives
☐ Yes ☐ No Heart Attack -Date_____
☐ Yes ☐ No Epilepsy or Seizures
☐ Yes ☐ No Bladder disease
☐ Yes ☐ No Venereal Disease
☐ Yes ☐ No PhenPhen/Redux
☐ Yes ☐ No AIDS
☐ Yes ☐ No HIV +
☐ Yes ☐ No Ulcers
☐ Yes ☐ No Fibromyalgia
☐ Yes ☐ No Lupus
☐ Yes ☐ No Osteoporosis
☐ Yes ☐ No Pacemaker
☐ Yes ☐ No Nervousness
☐ Yes ☐ No Anemia
☐ Yes ☐ No Arthritis
☐ Yes ☐ No Diabetes_____
☐ Yes ☐ No Hepatitis A B C
☐ Yes ☐ No Asthma
☐ Yes ☐ No Rheumatic Fever

Females:

☐ Yes ☐ No Do you have trouble with your periods? (If you do not menstruate, answer no.)
☐ Yes ☐ No Did you have any complication during pregnancy (If you haven't been pregnant, answer no.)_____
☐ Yes ☐ No Areyou pregnant? Date of delivery:_____
☐ Yes ☐ No Are you taking oral contraceptives (Birth control pills)?_____

To the best of my knowledge all of the above answers are true and correct, if I have any change in my health, I will inform **Dr. AristidisPontikas** at my next appointment.

_____ _____
Signature of Patient Date

AristidisPontikas, D.M.D., M.S., P.L.L.C.

Release and Financial Responsibility Agreement

I understand that I am personally responsible for complete payment of all services, treatments, and products at the time dental services are rendered unless, financial arrangements have been made prior to consultation and presented to me in writing, bearing signature of authorized personnel within the practice of Dr. AristidisPontikas. I understand where appropriate, credit reports may be obtained, to facilitate payment arrangements if so desired.

I hereby authorize payment directly to Dr. AristidisPontikas for dental benefits if any, otherwise payable to me for **any** services provided.I understand that I am financially responsible for any charges/fees not covered by my dental insurance provider. I further understand that any co-payments or monies paid toward dental treatments/procedures performed in the facility is **ONLY AN ESTIMATE**, and actual amounts owed will be determined at the time dental insurance claims payments have been paid in full.

In the event of default on my behalf of this agreement, I agree to pay interest, legal fees, collection costs, and attorney fees incurred as a result of nonpayment. I understand that if the entire balance on my account is not paid in full within (30) calendar days after receipt of notification of delinquency, finance charges will be assessed, and my account with Dr. AristidisPontikas will be adjusted to reflect the aforementioned. I understand that it is my responsibility to update my records at Dr. AristidisPontikas' office in the event of any address, phone number or insurance changes immediately. I will be held liable for any repercussions as a result of my failure to report such changes.

I understand that I will provide Dr. AristidisPontikas with notification at least **one week** prior for surgical procedures, and **two business days** prior for non surgical appointments of any cancellations other than emergencies.

I hereby authorize Dr. AristidisPontikas to release any information acquired in the course of examination or treatment to my insurance carrier or other dental/medical professionals.

_____ _____

Patient/Guardian Signature (Required if a minor)

Date

_____

Staff signature/Witness

AristidisPontikas, D.M.D., M.S., P.L.L.C.

Consent for use and disclosure of health information
Purpose: In cases where Dr. AristidisPontikas as directed not to rely on acknowledgements as a basis to use or disclose health information, this form is used to obtain a patient's consent to use and disclose the patient's protected health information to carry out treatment, payment activities, and healthcare operations, as described more fully in our Notice of Privacy Practices.

SECTION A: PATIENT GIVING CONSENT

Name:_____

Address:_____

Telephone: _____ E-mail _____

Social security #_____

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 is available upon request. 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 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: Sunny, or Dr. AristidisPontikas
301 East Bethany Home Road, Suite B-120
Phoenix, AZ 85012
Telephone (623) 934-1676 Fax (623) 934-6630

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 a personal representative on behalf of the patient signs this consent, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed consent in the patient's chart.