Smile ARIZONA
Dr. Beth Vander Schaaf, D.D.S.

WELCOME TO OUR OFFICE

We appreciate your selection of our office for your dental health and esthetic needs!

Our mission is to provide you quality dental care, esthetics and education that will enhance your health and appearance for a lifetime. We aim to exceed your expectations with our care, service and results in a comfortable environment using current technology with proficiency. In addition to being a full-service dental office, we are proud to offer **Botox** injections (for both medical and cosmetic implications), **fillers** and the **Opus Plasma** for skin resurfacing and smoothing.

OFFICE HOURS:

Dental treatment hours are Monday through Thursday 8am to 5pm and Monday and Friday by appointment. The office is closed for major holidays as well as times when our doctors and team are attending continuing education seminars to keep abreast of the latest technology so that we may better serve you. Dental specialty care is available in our office, with subcontracted providers, for your convenience.

EMERGENCIES & SCHEDULING POLICY:

One of our doctors can be reached 24 hours a day for emergencies, simply call our office phone number and follow the directions. In return we ask for your agreement in providing us a full 48 business hours' notice if you need to reschedule an appointment. We respect your time, thank you for respecting ours. A charge will be made for broken/canceled appointments with less than 48 business hours' notice so that we can operate in the most cost-effective and high-quality way that benefits all our patients. **Appointments rescheduled less than 48 hours in advance and missed appointments are subject to a minimum $50/hour broken appointment fee.** Your card on file will be automatically run for any missed appointment.

FINANCIAL AND "INSURANCE":

A deposit or insurance co-pay is required to schedule procedures with the doctor. We bill your insurance carrier for services performed on your behalf and accept payment from your carrier for those services. You are responsible for the estimated patient portion when scheduling and any residual due, if any, after insurance pays a claim. Your carrier communicates the same correspondence to us both. When a claim is paid, your card on file will be charged if there is a residual due and we will send an email with corresponding paperwork. As a courtesy to you, if your carrier denies a claim, we will appeal the decision one time. If your carrier denies our appeal, you will be responsible for the unpaid balance. Unpaid balances that are left unpaid in excess of 30 days are subject to a service fee. Accounts with an outstanding balance over 45 days will accrue 18% of the remaining balance. Any additional fees assessed to our office by outside companies (collection agency, attorney, etc.) will be added to your balance

Method for Resolving Discomfort: All parties desire a method for resolving misunderstandings, disputes, discomfort, if any should occur-privately, quickly, and economically and in a friendly, educational manner. We therefore agree to resolve these matters using the communication, negotiation, mediation, and arbitration procedures set forth in the latest edition of the Law Forms Integrity Agreement. You may receive a copy of this standard form and information about it from our office. Unless we hear from you to the contrary, we shall assume that you are familiar with the LawForms Integrity Agreement or have taken the time to review and understand it.

I HAVE READ AND UNDERSTAND THE ABOVE "WELCOME TO OUR OFFICE".

_____ _____

Signature of Responsible Party : Date:

_____

Printed Name of Responsible Party :

Smile ARIZONA
Dr. Beth Vander Schaaf, D.D.S.

7327 E. Thomas Rd. Scottsdale, AZ 85251
Smilearizonadentistry.com | 480-994-5225

In Event of an Emergency:

Who should we contact?_____

Relation:_____

Home Phone #:_____

Work or Cell #:_____

M.D. Name:_____

M.D. Phone #:_____

List Medical Specialists you see, (please include phone numbers): _____

_____

_____

_____

_____

_____

Nearest Friend or Relative not living with you:

Name: _____

Phone#: _____

Today's Date: _____

Whom may we thank for referring you to our office? _____

Patient Name: _____
Last First MI

What You Prefer To Be Called: _____ ◯ M ◯ F Other

Birthdate: _____ Age: _____ SS#: _____

Mailing Address: _____

_____ Apt/Suite#

Zip: _____ City: _____

Home Phone#: _____ Work Phone #: _____

Cell Phone #: _____

E-mail Address: _____

Employer: _____

Employer's Address: _____

_____

Occupation:_____

Status: ◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed

Spouse's Name: _____

Do you have children? ◯ Yes ◯ No How Many? _____

Person ultimately responsible for account:

Name:_____

Relation: _____

Address: _____

_____

SS #:_____

(Please provide a copy of driver's license)

Driver's License #: _____

State:_____ Expiration:_____

Cell/Home Phone: _____

Work Phone: _____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any and all balances not paid by my insurance company within 45 days.

_____ **Initials**

Primary Dental Insurance (if any)

Co. Name:_____

Address: _____

_____

Phone #: _____ Group #: _____

Insured's Name: _____ Relation:_____

Date of birth: _____ SS#: _____

Insured's Employer:_____

Insured ID#:

Secondary Dental Insurance (if any)

Co. Name:_____

Address: _____

_____

Phone #: _____ Group #: _____

Insured's Name: _____ Relation:_____

Date of birth: _____ SS#: _____

Insured's Employer:_____

Insured ID#:

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Do you have or have you ever had any of the following diseases, medical conditions or procedures?

Y N **AIDS/ARC Aids Related Complex**
Positive HIV Blood Test
When? _____
Y N **Allergy to Anesthetics**
What? _____
Y N **Allergy to Latex Rubber Reaction?** _____
Y N **Anemia**
Y N **Any Bleeding/Clotting or Other Blood Disorders** _____
Y N **Any Allergies (Note Below)**
Y N **Anorexia/Bulimia/Any Eating Disorder**
What? _____
Y N **Arthritis/Rheumatism**
Y N **Asthma**
Y N **Back Problems**
What?_____
Y N **Blood Transfusion**
When?_____
Y N **Cancer/Tumors**
Diagnosed_____
Y N **Radiation or Chemotherapy?**
When?_____
Y N **Chemical/Alcohol Dependency**
What?_____
Consumed/week_____
Y N **Circulatory Problems**
Y N **Cosmetic surgery:**_____
Y N **Wear Contact Lenses**
Y N **Emphysema**
Y N **Depression treatment:**_____
Y N **Diabetes reading:**_____
Y N **Difficulty Breathing/Respiratory Problems**
Y N **Epilepsy/Seizures**
Y N **Fainting**
Y N **Frequent Fever**
Y N **Frequent Neck Pain**
Y N **Glaucoma**
Y N **Hay Fever**
Y N **Headaches;** Frequency:_____
Severity:_____
Y N **Hearing loss/Aids**
Y N **Heart Problems of any type**
Y N **Heart attack/stroke** when_____
Y N **Heart Surgery** when_____
Y N **Heart Murmur** diagnosed:_____
Y N **Rheumatic Fever, Scarlet Fever or Congenital Heart defect**
Y N **Angina/Chest Pains**
Y N **Artificial Heart Valve**
Y N **Mitral Valve Prolapse/Floppy Valve**
Y N **Pacemaker** placed:_____
Y N **High blood pressure**
Y N **Low Blood Pressure**
Y N **Hepatitis type**_____
Y N **Hypoglycemia**
Y N **Implants of any type**
What?_____
Artificial Joints etc. :_____
Y N **Jaw Problems - TMD/TMJ**
Left Right Both (circle one)
Y N **Kidney Disease**
Y N **Liver Disease**
Y N **Nervous Problems**
Y N **Night Sweats**
Y N **Recreational Drug Use**
what:_____
Y N **Shingles** when:_____
Y N **Sinus problems**
Y N **Swollen Lymph Nodes**
Location:_____
Y N **Thyroid Condition** what_____
Y N **Tuberculosis/TB** when_____
Y N **Ulcer/Stomach Problems**
Y N **Unexplained Weight Loss**
Y N **Have you had botox?**_____
Y N **Have you had dermal fillers?**_____
Y N **Have you had skin rejuvenation?**___

Reason for today's visit: [] Exam [] Emergency [] Consultation
Are you in pain? [] Yes [] No How long? _____

Please indicate any of the following problems:
[] Discomfort, Clicking, Popping or Locking Jaw [] Lost/Broken Filling(s) [] Stained Teeth
[] Red, Swollen or Bleeding Gums [] Teeth Grinding/Clenching [] Bad Breath
[] Sensitive Tooth, Teeth, Gums or Jaw [] Ringing in Ear [] Other: _____
[] Blisters/Sores in or Around the Mouth [] Broken/Chipped Teeth _____
[] Food Catching Between Teeth [] Swelling or Sore(s) in Mouth _____

Do you require pre-medication? [] Yes [] No [] Don't Know
Previous Dentist:_____ Phone #:_____
Last Dental Exam:_____ Last Dental X-Rays:_____
How often do you brush? _____ How often do you floss?_____
What type of toothbrush do you use? [] Manual (what kind) _____ [] Electric (what kind) _____

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)
Are you satisfied with your smile? [] Yes [] No
Do you have dental anxiety? (None) 1 2 3 4 5 6 7 8 9 10 (High)
Have you ever had your teeth straightened? [] Yes [] No
Have you had any unfavorable reaction associated with dental treatment? [] Yes [] No
If yes, please explain:_____
Have you been satisfied with your previous dental care? [] Yes [] No
If no, please explain:_____
Would you like to keep your natural teeth? [] Yes [] No
Have you ever been treated for Periodontal Disease (Gum Disease)? [] Yes [] No
Has anyone in your family ever been treated for Periodontal Disease? [] Yes [] No
Do you have any removal partials or dentures? [] Yes [] No

Please list all medications you take, prescription and over the counter, include vitamins, herbals & supplements:
_____
_____

Are you taking any of the following medications?
[] Nerve Pills [] Pain Killers (including aspirin) [] Muscle Relaxers [] Stimulants
[] Blood Thinners [] Tranquilizers [] Insulin [] Other(s): _____

Please list any other medical condition(s) you have or ever had:
_____

Are you allergic to any of the following?
[] Latex [] Penicillin/Amoxicillin [] Tetracycline [] Aspirin [] Dental Anesthetics
[] Others: _____
Do you use tobacco? [] No [] Yes - How Used? _____ How Much? _____ How long? _____
Please rate your general health from 1-10: _____
For Women: Are you taking birth control pills? [] No [] Yes

* Antibiotics can make the pill ineffective for one month past month(s) of ingestion *
Are you pregnant? [] No [] Yes/How Long? _____ Are you nursing? [] No [] Yes

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient. Our policy requires that patient portion is paid in full for all services rendered by the time of visit. If account is not paid in full within 45 days of the date of service, regardless of insurance status, you will be responsible for interest charges, collection agency fees and any other expenses or legal fees incurred in collecting your account.

- I give authorization to the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims or to aid in my treatment at any dental specialist to which I or the patient is referred.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes to the information that I have provided.
- I give my permission to have my health discussed with my medical doctors of record and those that I have noted on this form.
- I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") I have certain rights to privacy regarding my protected health information. Details available at the front desk.

Signature: _____ Date: _____

[] Adult Patient [] Parent or Guardian (print name) _____

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As part of our commitment to your overall health, we screen for oral cancer in our office.

We appreciate your cooperation in answering the questions on the attached page as part of our HPV oral cancer screening process.

HPV oral cancer is harder to discover than tobacco related cancers because the symptoms are not always obvious to the individual who is developing the disease, or to professionals that are looking for it. They can be very subtle and painless. A dentist should evaluate any symptoms that you are concerned with, and certainly anything that has persisted for two or more weeks.

Facts you should know about oral cancer

- The age group most affected by HPV oral cancer is 25-50 year olds.
- HPV contributes to 40-80% of new oral cancer in the US.
- Early diagnosis equates to an 80-90% survival rate and is paramount in treatment success.
- 100 new cases of oral cancer are diagnosed every day.
- One American dies every hour from oral cancer.
- HPV cancer is deep within the tissues and further back in the mouth and throat therefore, we need your help in reporting symptoms.

What we now know about HPV Oral Cancer

- There are 130 strains of HPV viruses, only a handful are oncogenic (cancer causing).
- HPV-16 causes cervical cancer and oral cancer. Men have a 3X greater ratio of HPV cancer over women.
- HPV virus is transmitted via skin to skin contact (transfer between epithelial cells)
- The HPV virus infects at least 50% of all people who have had sex at some time in their lives.
- Those that engage in sexual contact with 5 or more partners are at greatest risk.
- HPV is related to oral autoimmune conditions and periodontal disease
- 7% of patients diagnosed with oral cancer have no identifiable cause (other risk factors have yet to be identified).

To adequately screen for HPV-related oral cancer and rule out other conditions, we ask that you answer the following questions:

- Have you experienced any swelling or pain in your face, mouth, neck, tonsils, or throat areas? Yes No
  If yes, please explain_____
- Do you have any painless, non-moving firm bumps on your neck? Yes No
  If yes, please explain_____
- Have you ever had a mouth sore that lasted more than two weeks? Yes No
  If yes, please explain_____
- Have you ever experienced any oral bleeding? Yes No
  If yes, please explain_____
- Have you recently noticed a change in the way things taste? Yes No
  If yes, please explain_____
- Have you recently noticed a change in the way your voice sounds? Yes No
  If yes, please explain_____
- Have you had any changes in the surface of your mouth? Yes No
  If yes, please explain_____
- Have you experienced any problems while eating or swallowing? Yes No
  If yes, please explain_____
- Have you recently had any changes to your weight? Yes No
  If yes, please explain_____
- Have you experienced any numbness or tingling in your face? Yes No
  If yes, please explain_____
- Have you had any recent changes in your vision? Yes No
  If yes, please explain_____
- Can you tell me about your vaccination history? Yes No
  If yes, please explain_____

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Weight	Pounds	**Age**	Years	Gender **Male** ○ **Female** ○	Tally ARES Risk Points
Height	Feet / Inches	**Neck Size**	Inches		Neck Size +2 Male ≥16.5 +2 Female≥15.0
ID Number	Optional				Score

COMPLETELY FILL IN ONE CIRCLE FOR EACH QUESTION – ANSWER ALL QUESTIONS

Have you been diagnosed or treated for any of the following conditions?

High blood pressure	Yes ○	No ○	Stroke	Yes ○	No ○
Heart disease	Yes ○	No ○	Depression	Yes ○	No ○
Diabetes	Yes ○	No ○	Sleep apnea	Yes ○	No ○
Lung disease	Yes ○	No ○	Nasal oxygen use	Yes ○	No ○
Insomnia	Yes ○	No ○	Restless leg syndrome	Yes ○	No ○
Narcolepsy	Yes ○	No ○	Morning Headaches	Yes ○	No ○
Sleeping Medication	Yes ○	No ○	Pain Medication e.g., vicodin, oxycontin	Yes ○	No ○

Co-morbidities +1 for each Yes response

Score

Do not assign any points for these eight responses

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

0 = would never doze **1 = slight chance of dozing**
2 = moderate chance of dozing **3 = high chance of dozing**

	0	1	2	3
Sitting and reading	○	○	○	○
Watching TV	○	○	○	○
Sitting, inactive, in a public place (theater, meeting, etc)	○	○	○	○
As a passenger in a car for an hour without a break	○	○	○	○
Lying down to rest in the afternoon when circumstances permit	○	○	○	○
Sitting and talking to someone	○	○	○	○
Sitting quietly after lunch without alcohol	○	○	○	○
In a car, while stopped for a few minutes in traffic	○	○	○	○

Epworth Score **TOTAL** the values from all 8 questions, If 11 or less **Score = 0** If 12 or more **Score = 2**

Score

Assign points for each of the first three responses

Frequency	**0 - 1 times/week**	**1 - 2 times/week**	**3 - 4 times/week**	**5 - 7 times/week**

On average in the past month, how often have you snored or been told that you snored?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Do you wake up choking or gasping?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Have you been told that you stop breathing in your sleep or wake up choking or gasping?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Do you have problems keeping your legs still at night or need to move them to feel comfortable?
Never ○ Rarely ○ Sometimes ○ Frequently ○ Almost always ○

Signature	Area Code Phone Number	**Total all 6 boxes from above** **If point total = 4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)**	**Point Total**

Smile ARIZONA BEAUTY

Beauty For Your Smile, Face & Skin

SKIN HEALTH QUESTIONNAIRE: COSMETIC MEDICAL TREATMENTS

Please take a few moments to answer the questions below. We are pleased to offer non-surgical aesthetic procedures. Let us know if you would like more information on any of our newer services.

Please return to front desk after completing.

Would you be interested in receiving facial rejuvenation treatments? Yes ___ No ___

If yes, which conditions are you interested in having treated?

Vertical Lip Lines ___ Lines Around Mouth ____ Age Spots ___ Fine Lines/Wrinkles on Face ___
Crow's Feet ____ Enlarged Pores ___ Sagging Skin ___Texture ____ Tone ____ Scars/Acne Scars ____
Loss of Volume ____ Neck Lines ____Neck Laxity ____ Other ____

Would you be interested in a FREE Cosmetic Consultation? Yes ___ No ____

☐ Yes! Please contact me with new information on cosmetic procedures, products and specials.

Name _____

Cell Phone: _____

Email: _____

Signature: _____

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Insurance Agreement

To our patients requesting that we file your insurance: please read and sign this form (responsible party) for us to accept payment directly from your insurance company.

1. Please remember that professional dental services are rendered and charged to you, the patient, not to an insurance company. You are responsible for the payment of all treatment fees on your account. If your insurance company fails to pay within **45 days**, you are agreeing to pay your account in full. We will continue to re-file paperwork, etc. on your behalf and always exhaust your options.

2. We will file but cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a claim. You are responsible for payment of your account.

3. Insurance deductibles and "co-payment" portions are due to schedule or as services are rendered.

4. Our office is willing but cannot make a totally accurate estimate of your insurance benefits to be paid since we do not have access to your insurance company records and insurance companies generally will only discuss exact fees with the people they insure. Many insurance companies pick and choose randomly what they will and will not cover. It is your sole responsibility to know the terms, agreements and amounts of coverage of your dental/medical insurance benefit contracts.

5. After each insurance claim is paid to our office by your carrier, we email or mail you a statement reflecting your current account balance. This statement shows any difference between the estimated coverage and the final amount your insurance company paid on your behalf. We respectfully request that you pay any difference promptly as indicated to keep your account balance paid in full. *This may generate more than one billing per month as we keep you informed regarding all action on your account.*

6. Thank you! We are happy to answer any inquiries regarding your account(s). And we will certainly make every effort to help you receive full value for any dental "insurance" you participate in. **We appreciate all your efforts in keeping your account current so we can focus our efforts on patient care.**

Our conscience and desire for your optimal health drives our treatment plans; not limitations or restrictions imposed by third parties.

_____ _____
Signature of Responsible Party Date

_____
Printed Name of Responsible Party

_____
Printed Name of Patient (If different from Responsible Party)

Dr. Beth Vander Schaaf

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____, have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, as required by law, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify:

_____

Medical Insurance Information (Not Dental Insurance)

Insurance Company: _____

ID#: _____

Group#: _____

Subscriber: _____

Subscriber DOB: _____

Relationship to Patient: _____

Insurance Phone Number: _____

Insurance Company Address:

_____

_____

Secondary Medical Insurance Information (if applicable)

Insurance Company: _____

ID#: _____

Group#: _____

Subscriber: _____

Subscriber DOB: _____

Relationship to Patient: _____

Insurance Phone Number: _____

Insurance Company Address:

_____

_____