H. Kendall Scholes, DMD, MS, PLC

595 North Dobson Road, Bldg. B, Suite 34
Chandler, AZ 85224

Ph 480 786 9040 Fx 480 786 5694

www.scholesperio.com

Patient Information

Name:_____ Birth Date:_____ Gender:____
Last First MI Preferred Name

Address:_____
Street Apt # City State Zip Code

Check appropriate box: ☐Single ☐Married

Social Security #:_____ Email:_____

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

Do you prefer to receive calls at: ☐Home ☐Cell ☐Work Best time to call:_____

Appointment reminder preference (check all that apply): ☐Phone call ☐Text Message ☐Email

Referral Information

Whom may we thank for referring you to our practice? ☐Patient ☐Dental Office ☐Internet ☐Other:_____

Name of person or dentist referring you to our practice:_____

Responsible Party (Minors Only)

The following is for: ☐Parent ☐Person responsible for payment

Name:_____ Birth Date:_____ Relation: _____
Last First MI

Address:_____
Street Apt # City State Zip Code

Check appropriate box: ☐Single ☐Married

Social Security #:_____ Email:_____

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

Do you prefer to receive calls at: ☐Home ☐Cell ☐Work Best time to call:_____

Employment

The following is for: ☐Patient ☐Person responsible for payment

Employer Name:_____ Occupation:_____ Phone:_____

Address:_____
Street Ste # City State Zip Code

Insurance Information

Is the policy holder a patient? ☐Yes ☐No Patient's relationship to insured: ☐Self ☐Spouse ☐Child

Insured's Name:_____ _____ Insured's Birth Date:_____
Last First MI

Insured's Address:_____
Street Apt # City State Zip Code

Insured's Employer Name:_____ Address:_____

Insurance:_____ ID: _____ Group #:_____

Phone #:_____ Address:_____

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Updated Health History Form

Name:_____DOB:_____Occupation:_____

Address:_____City:_____St:_____Zip:_____

__

Phone:_____Email: _____

Please check all that apply:

- ❑ AIDS
- ❑ Seasonal Allergies
- ❑ Anemia
- ❑ Artificial joints
- ❑ Asthma
- ❑ Blood Disease
- ❑ Cancer
- ❑ Diabetes
- ❑ Dizziness
- ❑ Epilepsy
- ❑ Excessive Bleeding
- ❑ Fainting
- ❑ Glaucoma
- ❑ Growths/Tumors
- ❑ Hay fever
- ❑ Head injuries
- ❑ Heart Disease
- ❑ Heart Murmur
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ Jaundice
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mental Disorders
- ❑ Nervous Disorders
- ❑ Pacemaker
- ❑ Pregnancy (due date:____)
- ❑ Radiation Treatment
- ❑ Respiratory Problems
- ❑ Rheumatism
- ❑ Sinus Problems
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Tumors
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Codeine Allergy
- ❑ Penicillin Allergy
- ❑ Latex Allergy

Do you smoke?
Yes_____No____
If no longer, when did you quit?_____

Do you drink alcohol?
Yes_____No_____

Do you take thinners?
Yes_____No_____
Name of Medication?
_____

Do you take an antibiotic premedication before dental appointments? Yes_____No_____
(For artificial joints, cardiac issues, or other medical conditions?)
Are you currently taking any drugs or medications?Yes_____No_____
If yes, please list_____

Are you allergic to any medications?Yes____No_____
If yes, please list
allergies:_____
Are you currently under the care of a physician for any medical concerns?Yes____No____
Name of
Physician:_____
Medical
concern(s):_____

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Have you had an excessive bleeding during or following dental treatment?Yes____No____

Who is your current general dentist?_____

Signature of patient, parent, or guardian _____ Date _____

Dr. Signature: _____ Date _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctors at the next appointment without fail.

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Financial Policies

Welcome to our practice and thank you for your confidence and trust placed in our services. Please take a few moments to review our financial policies.

Payment is expected at the time of treatment. This includes deductibles and any estimated patient financial responsibilities. Our office accepts the following payment options:

1. Cash - This includes checks and money orders.
2. Credit cards - Visa, MasterCard, American Express and Discover.
3. Extended Payment Plans - Please ask us for more information.

Our office will bill your dental insurance as a courtesy to you; however, please keep in mind that insurance plans do not cover 100% of the cost of your treatment. If your insurance company has not paid within 45 days from the date of service, the balance in full will become your responsibility. We will provide you with reimbursement documentation, if necessary.
Initial_____

Our office requires **two business days** cancellation notice for all surgical appointments, and **one business day** for all other appointments. A $150.00 fee will be assessed for broken or failed surgical appointments, and a $50.00 cancellation fee for all other appointments. A 25% non-refundable deposit may be required prior to scheduling some surgical procedures. This deposit will not exceed $500.00.
Initial_____

I further agree to pay all finance charges, collection cost, attorney fees, and any other costs that may be incurred to enforced collection of any outstanding amount.
Initial_____

A $25.00 fee will be charged on all returned checks. The account will then become payable by cash only.

I_____, acknowledge that I fully understand these policies. I also authorize my dental insurance company to make payment of my dental benefits to H. Kendall Scholes D.M.D., M.S., P.L.C.

_____ _____
Signature of responsible party Date

Printed Name of Patient or Legal Representative _____

Date_____

** a printed copy of the Notice of Privacy Practices is given upon request*