



Combined New Patient Packet

Kokopelli Family & Cosmetic Dentistry · Ahwatukee & Chandler, AZ

TODAY'S DATE _____

Welcome — we're glad you're here. Please complete every section; your answers stay confidential and help us take great care of you.

1 About You

First Name	Middle Name	Last Name	Date of Birth	
Address		City	State	Zip Code
Email	SSN #	Gender	Marital Status	
Cell Phone	Home Phone	Work Phone		
Emergency Contact Name	Emergency Contact Phone	Relationship		
Who may we thank for inviting you?				

2 Dental Insurance

Skip this section if you don't have dental insurance, or if you've already shared a copy of your insurance card with the front desk

Policy Holder's First Name	Policy Holder's Last Name	Policy Holder's DOB	Policy Holder's SSN #
Relationship to Policy Holder	Employer	Insurance Company	
Insurance Phone #	Subscriber ID	Group #	

Insurance card: please hand your card to our front desk — we'll scan the front and back for your file.

3 Dental History

How long ago was your last visit to the dentist? ☐ 1 month ☐ 3 months ☐ 6 months ☐ Less than 1 year
☐ 1–2 years ☐ 2–3 years ☐ 3–5 years ☐ More than 5 years ☐ I've never seen a dentist

I routinely see my dentist every: ☐ 3 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ Not routinely
Previous dentist — name, address & phone _____ Date of most recent exam & x-rays _____

How did you find us? ☐ Another patient — name: _____ ☐ Friend / Colleague ☐ Google ☐ Internet
☐ Nextdoor App ☐ Other

Reason for today's visit: ☐ Check-up ☐ Pain ☐ Other: _____

What is your immediate dental concern? _____

Have you ever had a bad experience at the dentist? ☐ Yes ☐ No If yes, please explain: _____

Have you had any complications following treatment? ☐ Yes ☐ No If yes, please explain: _____

Any unfavorable reactions to dental anesthetic? ☐ Yes ☐ No If yes, please explain: _____

Teeth sensitive to cold or hot temperatures?

☐ Yes ☐ No

Do you grind your teeth? ☐ Yes ☐ No

Aware of sores or irritated areas in your mouth?

☐ Yes ☐ No

Ever been treated for periodontal (gum) disease?

☐ Yes ☐ No

Do your gums bleed when you brush or floss?

☐ Yes ☐ No ☐ Sometimes

Does dental treatment make you nervous? ☐ No

☐ Slightly ☐ Moderately ☐ Extremely

How often do you brush? ☐ Never ☐ Occasionally ☐ Once a day ☐ Twice a day ☐ Three times a day

☐ Every time I eat Brush type: ☐ Manual ☐ Electric ☐ Both

How often do you floss? ☐ Never ☐ Occasionally ☐ Once a day ☐ Twice a day ☐ Three times a day

☐ Every time I eat Condition of your mouth: ☐ Poor ☐ Good ☐ Excellent

Check all that apply:

- ☐Had complications from past dental treatment
- ☐Had / have experienced dry mouth
- ☐Experienced gum recession
- ☐Teeth sensitive to biting or sweets, or avoid brushing part of the mouth
- ☐Wear or have worn a bite appliance or night guard
- ☐Notice spaces developing between teeth
- ☐Food gets trapped between any teeth
- ☐Clench or grind your teeth
- ☐Experienced a burning sensation in the mouth
- ☐Notice teeth becoming more loose
- ☐Had trouble getting numb
- ☐Popping / clicking of the jaw joint, or a limited opening
- ☐Notice teeth becoming more crooked, crowded, or overlapped
- ☐Have difficulty chewing
- ☐Had teeth become loose on their own (without injury)
- ☐Had / have braces or orthodontic treatment
- ☐Have whitened or bleached your teeth
- ☐Noticed an unpleasant taste or odor in your mouth
- ☐Snore or wake up frequently during the night

Your Smile

Do you like your smile? ☐ Yes ☐ No

If you could change your smile, what would you change? ☐ Color of my teeth

☐ Position / alignment of my teeth ☐ Close spaces or restore worn / broken teeth ☐ Shape of my teeth

☐ Other

I am interested in: ☐ Teeth whitening ☐ Straight teeth ☐ Replacement of missing teeth

☐ White fillings ☐ Other

To make your visit a great experience, any questions or concerns you'd like us to know about?

4

Health History

Your answers are for our records only and are kept confidential

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. You may be asked some questions about your responses, and there may be additional questions concerning your health — this information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Patient First Name	Patient Last Name	Date of Birth	Pharmacy Name
Pharmacy Cross Streets & Phone Number		Emergency Contact — Name / Relationship / Phone (if different from page 1)	

Are you now under the care of a physician? ☐ Yes ☐ No

Physician Name	Phone #	Address / City / State / Zip
----------------	---------	------------------------------

Any change in your general health within the past year? ☐ Yes ☐ No

Date of last physical exam:

Serious illness, operation, or hospitalization in the past 5 years? ☐ Yes ☐ No

If yes, what was the illness or problem?

Tuberculosis screening — do you have any of the following?

Active tuberculosis

☐ Yes ☐ No

Persistent cough greater than a 3-week duration

☐ Yes ☐ No

Cough that produces blood

☐ Yes ☐ No

Been exposed to anyone with tuberculosis

☐ Yes ☐ No

Medications — please list everything you are currently taking:

Medication Name	Comments / Dosage	Medication Name	Comments / Dosage

Are you taking, or scheduled to begin taking, an antiresorptive agent (Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?

☐ Yes ☐ No Date treatment began: _____

Do you use controlled substances (drugs)? ☐ Yes ☐ No

Do you use tobacco (smoking, snuff, chew, bidis)? ☐ Yes ☐ No

If so, how interested are you in stopping? _____

Do you drink alcoholic beverages? ☐ Yes ☐ No If yes — in the last 24 hours: _____

In a typical week: _____

Women only — are you: Pregnant? ☐ Yes ☐ No If pregnant, how many weeks: _____

Taking birth control pills? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

5 Allergies

Check anything you are allergic to or have had a reaction to

☐ Amoxicillin	☐ Antihistamines	☐ Aspirin	☐ Bactrim	☐ Betadine
☐ Biacin	☐ Clindamycin	☐ Codeine	☐ Erythromycin	☐ Fluoride
☐ Hay fever	☐ Iodine	☐ Keflex	☐ Latex	☐ Lidocaine
☐ Morphine	☐ Mupirocin	☐ Omeprazole	☐ Oxycodone	☐ Penicillin
☐ Percocet	☐ Pollen	☐ Polytrim (eye drops)	☐ Seasonal allergies	☐ Sulf

☐ Other allergies: _____

6 Medical Conditions

Check anything you have or have had

☐ A-Fib (atrial fibrillation)	☐ Anemia	☐ Angina pectoris	☐ Anxiety
☐ Arthritis	☐ Artificial heart valve	☐ Artificial joints	☐ Asthma
☐ Back problems	☐ Blood disease	☐ Blood transfusion	☐ Cancer
☐ COPD	☐ Depression	☐ Diabetes	☐ Dizziness
☐ Drug addiction	☐ Epilepsy	☐ Excessive bleeding	☐ Fainting
☐ Glaucoma	☐ Head injuries	☐ Heart conditions	☐ Heart disease / heart attack
☐ Heart implant	☐ Heart murmur	☐ Heart surgery	☐ Hepatitis
☐ High blood pressure	☐ High cholesterol	☐ HIV positive	☐ Inflammation of the joints
☐ Jaundice	☐ Kidney disease	☐ Lichen planus	☐ Liver disease
☐ Mental / nervous disorders	☐ "No epi" (avoid epinephrine)	☐ Osteoporosis	☐ Pacemaker
☐ Pain (chronic)	☐ Pregnancy	☐ Radiation treatment	☐ Respiratory problems
☐ Rheumatic fever	☐ Rheumatism	☐ Rheumatoid arthritis	☐ Seizures
☐ Sinus problems	☐ Stomach problems	☐ Stroke	☐ Thyroid disease
☐ Tuberculosis	☐ Tumors	☐ Ulcers	☐ Venereal disease

☐ Other — any disease, condition, or problem not listed above that you think we should know about: _____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment (pre-medication)?

☐ Yes ☐ No If yes: ☐ Amoxicillin ☐ Clindamycin ☐ Other: _____

Name of physician or dentist making the recommendation _____ Their Phone # _____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

☐ I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient / Legal Guardian

Date

7 Consent for Use & Disclosure of Protected Health Information

Section A: Patient Giving Consent

Initials: _____ Acknowledgement of Privacy Practices

Section B: To the Patient — please read the following statements carefully

By signing below, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. Our Notice of Privacy Practices describes these uses and disclosures in detail — it is posted in our office and available at any time; please ask our front desk for a copy. We may update our privacy practices as described in the Notice; you may request a current copy at any time by contacting:

Contact Person

Telephone

Fax

E-mail

- ☐ 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 of Patient / Legal Guardian

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

Stop. ONLY complete Section C if you do not consent.

Section C: Right to Revoke — please read carefully before signing

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 (Revocation of Consent)

Date

If this Revocation of 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. Include completed Consent in the patient's chart.

8 Appointment Cancellation & “No-Show” Policy

Along with high-quality dental work, our patients’ comfort and convenience are a top priority at Kokopelli Family & Cosmetic Dentistry — these values allow us to see patients at convenient hours such as late evenings and Saturdays. We confirm appointments a few days in advance, and any last-minute cancellations keep us from reaching out to other patients and taking care of them in time.

Weekday appointments: please confirm your appointment with us at least two business days in advance. Last-minute (less than two business days) cancellations and no-shows will result in a **\$50 charge**.

Saturday appointments: appointments not confirmed or cancelled at least three business days in advance are considered last-minute. Last-minute cancellations and no-shows for Saturday appointments will result in a **\$75 charge**.

- ☐ I have read and understand the Appointment Cancellation and “No-Show” Policy above, and I agree that the applicable fee may be charged to my account for last-minute cancellations or missed appointments.

Signature of Patient / Legal Guardian

Date