CHARISMA LUAT, D.D.S.

Aesthetic Dentistry of Glendale
Glendale AZ 85301

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell phone): _____

Email: _____

Address: _____
Street Apartment #

_____
City State Zip Code

How do you prefer to be contacted E-Mail ___ Cell Phone ___ Text ___ Other _____

What do you dislike about your smiles? _____

Date of Last Dental Visit: _____ Date of last Dental Cleaning_____

Previous Dentist_____ Reason for leaving (if applicable)_____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV
- ☐ Allergies _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints Date_____
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Attack Date_____
- ☐ Heart Murmur Date_____
- ☐ Hepatitis Type ___
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker Date_____
- ☐ Pregnant- Due date:_____
- ☐ Radiation/Chemo. Date_____
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke Date_____
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Fosamax / Actonel?

OTHER:

- ☐ _____
- ☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you taking any prescription medication?: _____
  please attach list if necessary
- Are you taking any over the counter medication?:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No (do not include if regular check ups only)
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  - If yes, please explain: _____

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

_____ _____
Signature Date

Referral

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐ Relative

☐ Newspaper ☐ Insurance Website ☐ Internet ☐ School ☐ Work ☐ Other _____

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

Responsible Party

Please fill this out if you are the parental guardian, power of attorney, or responsible for treatment decision and financial arrangements

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Dental Insurance

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street

City State Zip Code

Insurance Plan Name and Address: _

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street

City State Zip Code

Insurance Plan Name and Address:

CHARISMA LUAT, D.D.S.

Aesthetic Dentistry of Glendale
Glendale, AZ 85301
623-937.9241
adgsmiles@gmail.com

At least 48 hours notice is required for cancellation and/or rescheduling appointments.
Please call during office hours because the after-hours answering service does NOT accept appointment changes.

Failure to notify the office will result in a $75 fee per hour.

Financial:

Payment is expected when dental services are rendered.
Financial arrangements must be made in advance as a condition of your treatment by this office.

If your account requires collection proceedings, you will be responsible for the collection fees, legal fees, in addition to the balance and interest. A service charge of 1-1/2% per month (18% per annum) will be charged on unpaid balances exceeding 60 days, unless previously written financial arrangement are satisfied.

Treatment Plan:

A signed treatment plan is required prior to any dental treatment.
This signature acknowledges that you understand all aspects of the treatment discussed and accept your estimated financial responsibility.
The fee estimate given for the dental care can only be extended for a period of 30 days from the date on the treatment plan.

Insurance:

Payment from your insurance is not guaranteed, you are ultimately responsible for all charges.
The estimated co-insurance payment is subject to change.
Coverage approximate is based on information provided by your insurance during verification and may not disclose specific restrictions.
You are responsible for all denied claims or procedures.
If your claim not paid by your insurance in a timely manner (45 days), the unpaid balance will be immediately due.
You can then contact the insurance company for a reimbursement

Signature:_____ Date _____

I have read and accept the terms of the above specified policies

CHARISMA LUAT, D.D.S.

Aesthetic Dentistry of Glendale
5511 W Glendale
Glendale, AZ 85301
623-937-9241
adgsmiles@gmail.com

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

PRIVACY POLICIES ACKNOWLEDGEMENT

Patient Name:_____ Date: _____

Patient Date of Birth:_____ SS#: _____

I verify that the information given on the Health History is true and correct.

- I understand that the office and staff of Dr. Charisma Luat will make every reasonable effort to protect my personal health information including my social security number, date of birth, address, and phone numbers.

- I understand that there may be times when the Dr Luat and her staff will need to speak with me regarding an appointment time, dental consultations or financial arrangements. If I am not at the numbers given, they have my permission to leave a brief message at my home or other numbers provided.

- I give permission to the Dr Luat and her staff to correspond with my general physicians, hospital faculty or specialists that I am under care with.

- I understand that my dental health information will only be given to me or my legal guardian and can only be given to my spouse or other family members with my written consent.

- If I request, I will be given a full and complete copy of the HIPPA privacy policy.

- If there are specific restrictions on the use of my Personal Health Information, I will notify the staff at the office of Dr. Charisma Luat in writing of these restrictions.

_____

Signature of patient, parent or guardian