NATHAN JOHN SAYDYK, DDS, LLC

GENERAL DENTISTRY
Preventive Care
Crowns, Bridges
Dentures
Tooth Colored Fillings
Root Canals
In-house Oral Surgery

COSMETIC DENTISTRY
Whitening / Bleaching
Porcelain Veneers
Cosmetic Bonding & Reconstruction

480-926-0776

936 E. Williamsfield Road, Suite 102 Gilbert, Arizona 85296

Please complete the following Patient Registration and Confidential Health History

1 Step — *If the appointment is for **you**, Please Start Here*

Today's Date

Name | Sex

Street Address

City | State | Zip Code

Home Phone # | Work Phone # | Cell or Pager # *(if applicable)*

Driver License # | Birth Date | SS#

☐ Single ☐ Married ☐ Divorced ☐ Widowed | E-Mail Address

2 Step — *Insurance Information*

Group #

Dental Insurance Company | Phone #

Street Address

City | State | Zip Code

Employer | Phone #

Insured Employee Name | Birth Date

Date Employed | Insured Employee SS#

1 Step — *If the appointment is for **your child**, Please Start Here*

Todays Date

Child's Name | Sex

Street Address

City | State | Zip Code

Home Phone # | Birth Date | Age

School | Grade

3 Step — *Person Financially Responsible for Account*

Name

Address | City | State | Zip

Home Phone # | Work Phone # | Ext #

SS# | Drivers License #

Employer

Work Address | City | State | Zip

Spouse's Name

Employer | Work Phone # | Ext #

Work Address | City | State | Zip

4 Step — Getting to Know You

Referred to us by…or how did you hear about StoneRidge Dental?

Your Hobbies and Interests

Is a member of your family a patient in our office? ☐ Yes ☐ No

Their Name

Address City State Zip

5 Step — Emergency Contact Information

Name of an individual you would like us to contact in an emergency?

Address City State Zip

Home Phone # Work Phone # Ext #

Closest Relative ***not*** living with you?

Address City State Zip

Home Phone # Work Phone # Ext #

6 Step — Office Policies and Health Consent; Please Read:

As a condition of your treatment by this office, financial arrangements must be made in advance. Patient co-payments (the amount not covered by benefits) are due and payable at the time or service. Full explanation of financial policies are detailed on the StoneRidge Dental Financial Policy form included in the new patient folder.

I agree to review and abide by those policies detailed in the StoneRidge Dental Financial Policy. _____ Initials _____ Date

For the professional services rendered to me or my minor child or ward by the dentist, I agree to pay the reasonable value of services to said dentist or his assignee at the time services are rendered, or within thirty (30) days of billing if credit shall be extended. I further agree that the reasonable values of said services shall be as billed unless objected to by me, in writing, within the time for payment thereof.

I further agree that a waiver of any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fee if suit is instituted hereunder to collect monies owed by me, including interest, processing fees or commissions that may be assessed by any collection agency retained to pursue this matter.

I grant my permission to telephone me at home or at my workplace to discuss matters relating to this form.

I authorize assignment or payment of all dental and/or surgical benefits to which I or other family members are entitled, including dental benefit companies and other group health plan benefits otherwise payable to the undersigned, to Dr. Nathan John Saydyk.

I certify that I have answered all questions on the form accurately and I hereby agree to abide by the conditions outlined therein.

I certify that the answers to the health questions are accurate and correct to the best of my knowledge and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Dr. Nathan John Saydyk and/or such associates or assistants as he may designate, to perform those procedures as may be deemed necessary to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, other pharmaceutical agent (s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects which may include, but are not limited to, bruising, hematoma, cardiac stimulation, temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as a part of dental treatment, including preventive procedures of basic dentistry, teeth, gums and surrounding tissues may remain sensitive or possibly quite painful both during and after completion of treatment.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward.

I acknowledge that the nature and purpose of the foregoing procedures have been explained to me as necessary and I have been given the opportunity to ask questions, and have been informed of alternative treatment options that are avaliable.

7 Step — Please Sign Below

Signature of Patient, Parent or Guardian | *Date* | *Relationship to Patient*