PATIENT INFORMATION

(This information is necessary for our files and will be kept in compliance with HIPAA privacy laws.)

Date: ______________________

Patient's Name: ______________________ Age: ____ Birth Date: ______________________
LAST FIRST INITIAL

If patient is a minor, give parent's or guardian's name: ______________________ Relationship: ______________________

Residence Address: ______________________ Zip: ____________
STREET CITY STATE

Res. Phone: ______________ Cell Phone: ______________ Email Address: ______________________

Patient is: ❑ Male ❑ Female ❑ Married ❑ Single ❑ Minor Social Security # ______________________

Employed by: ______________________ Occupation: ______________________ Bus. Phone: ______________________

Name of nearest relative not living with you: ______________________ Relationship: ______________________

Relative's address: ______________________ Res. Phone: ______________________
STREET CITY STATE

Physician: ______________________
NAME ADDRESS PHONE NUMBER

Spouse's Name: ______________________ Occupation: ______________________ Soc. Sec. No: ______________________

Spouse's Business Address: ______________________ Bus. Phone: ______________________
STREET CITY STATE

Is another member of your family or relative a patient at our office? If so, who? ______________________

Whom may we thank for referring you? ______________________

Your Email

FINANCIAL INFORMATION

Person responsible for this account: ______________________ Relationship: ______________________

Address: ______________________ Phone No.: ______________________

Prepayment Options: Cash MasterCard VISA Discover American Express Care Credit Springstone

TERMS & CONDITIONS

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services furnished to me are charged directly to me, and I understand that with or without insurance, I am still fully responsible for payment of all dental services received.

I understand that the fee estimate listed for my dental treatment can only be extended for a period of six months from the date of the examination.

In consideration of the professional service rendered to me by the Doctor and his staff, I agree to pre-pay for the service, or pay within 10 days of billing if credit shall be extended. When credit is extended, a service fee is incurred on any unpaid balance that is older than 60 days. The service fee will be a minimum of two dollars or 1.5 percent per month (18 percent annually) of the unpaid balance whichever is greater.

I understand that if I cannot keep an appointment, I need to give at least a 48 business hour notice to avoid a missed appointment charge.

I have read the above conditions of treatment and agree to their content.

SIGNED: ______________________ DATE: ______________________

PLEASE COMPLETE BOTH SIDES!

HEALTH QUESTIONNAIRE

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.
Please answer each question. Circle **Yes** or **No** where applicable. Example: Do you brush your teeth?.......... Yes No

MEDICAL HISTORY

1. Are you in good health? .... Yes No
2. Date of last physical exam: ______
3. Are you now under the care of a physician? .... Yes No
   If so, what is the condition being treated? ______
4. Have you ever had any serious illness or operation? .... Yes No
   If so, what illness or operation? ______
5. Have you ever been hospitalized? .... Yes No
   If so, what was the problem? ______
6. Are you taking any medication? .... Yes No
   If so, what? ______ ______ ______ ______
   For what condition? ______ ______ ______ ______
7. Are you taking any recreational drugs? .... Yes No
   If so, what? ______
8. Are you sensitive or allergic to any drug? ❑ Penicillin; ❑ Tetracycline; ❑ Sulfa Drugs; ❑ Aspirin; ❑ Codeine;
   ❑ Other. If Other, what drugs? ______
9. Do you have, or have you had any of the following: (Please check ✓ known conditions)

❑ Anemia	❑ Cold Sores	❑ Sinus Trouble	❑ Blood Transfusion	❑ Pain in Jaw Joints	❑ Heart Ailments or Attack
❑ Herpes	❑ Hemophilia	❑ Blood Disease	❑ Joint Replacement	❑ Respiratory Disease	❑ X-ray or Cobalt Treatment
❑ Stroke	❑ Rheumatism	❑ Drug Addiction	❑ Nervous Disorders	❑ Sickle Cell Disease	❑ Fainting Spells or Seizures
❑ Ulcers	❑ Heart Murmur	❑ Kidney Disease	❑ Tumors or Growths	❑ Tuberculosis (T.B.)	❑ Chemotherapy (Cancer, Leukemia)
❑ Diabetes	❑ Bruise Easily	❑ Stomach Ulcers	❑ Allergies or Hives	❑ Epilepsy or Seizures	❑ Radiation Treatment
❑ Glaucoma	❑ Head Injuries	❑ Angina Pectoris	❑ AIDS Related Complex	❑ Artificial Prosthesis	❑ Hepatitis or Jaundice
❑ Arthritis	❑ Heart Failure	❑ Mental Disorder	❑ Excessive Bleeding	❑ HIV Titer positive	❑ Venereal Disease (Syphilis, Gonorrhea)
❑ Emphysema	❑ Liver Disease	❑ Rheumatic Fever	❑ Asthma	❑ Congenital Heart Lesions	❑ Acquired Immune Deficiency Syndrome (AIDS)
❑ Hay Fever	❑ Scarlet Fever	❑ Thyroid Disease	❑ High Blood Pressure	❑ Difficulty in Swallowing	❑ Chicken Pox
❑ Tonsillitis					❑ Other ______

10. Do you wear a cardiac pacemaker, or have you had heart surgery? .... Yes No
11. Do you smoke? If so, how much? ______ .... Yes No
12. Do you have any disease, condition, or problem not listed that you think I should know about? .... Yes No
13. (Women) Are you pregnant? If so, how many months? ______ .... Yes No
14. (Women) Do you take birth control pills? .... Yes No

DENTAL HISTORY

1. Have you ever had any serious trouble associated with any previous dental treatment? .... Yes No
   If so, explain ______
2. How long since your last full mouth x-rays? ______
3. How long since your last dental treatment? ______
4. Does dental treatment make you nervous? .... Yes No
   If yes, Check ✓. ❑ Slightly ❑ Moderately ❑ Extremely
5. Do you need to be pre-sedated (Valium, Nitrous oxide)? .... Yes No

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

CONSENT FOR TREATMENT: I hereby grant authority to the dentist in charge of care of the patient whose name appears on the reverse side of this form, to administer such anesthetics, analgesics, sedatives, and nitrous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

All services are rendered and accepted under the terms and conditions printed on the reverse hereof.

SIGNED: ______ **DATE:** ______
Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Relationship to the patient: ______

HIPAA Notice of Privacy Practices

7578 N. La Cholla Blvd. Tucson, AZ 85741 • (520)742-1991

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the dental practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to an endodontist, periodontist, or oral surgeon to whom you have been referred to ensure that the doctor has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining a dental insurance pre-estimate, or obtaining a dental insurance payment may require that your relevant protected health information be disclosed to your dental insurance company.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your dentist's practice. These activities include, but are not limited to, sending out lab work for crowns, bridges, dentures or partials, quality assessment activities, employee review activities, training of dental assistant students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to dental assistant students that train at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your dentist. We may also call you by name in the waiting room when your dentist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may also use or disclose your protected health information in the following situations without your authorization:

Public Health issues as required by law.	Communicable Diseases.	Health Oversight.
Food and Drug Administration requirements.	Abuse or Neglect.	Research.
Military Activity and National Security.	Criminal Activity.	Inmates.
As Required By Law.	Legal Proceedings.	Law Enforcement.
Coroners, Funeral Directors, and Organ Donation.	Workers' Compensation.	

Required Uses and Disclosures that may be made without your authorization: Under the law, we must make disclosures to you when requested. We must make disclosures to the Secretary of the Department of Health and Human Services when disclosure of information is required to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your dentist or the dental practice has taken an action in reliance on the use or disclosure indicated in the authorization.

2. Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your dentist is not required to agree to a restriction that you may request. If your dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your dentist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us, or to the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. You may file a complaint with us (at **520 742-1991**) by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____________________________

Signature:____________________________________Date__________

FINANCIAL ARRANGEMENTS AND TREATMENT POLICY

We feel that everyone benefits when there is a definite and clear understanding of our treatment and financial policies prior to treatment. They are intended to allow us to be fair to our entire family of patients and help control the administrative costs.

Appointments
Please be on time for your reserved appointments. We have exclusively reserved the doctor, staff and facilities for your personal dental care. In the event that you need to reschedule, we would appreciate your consideration in giving our office a **48 business hour notice** so that we may effectively re-utilize the time with the doctor or hygienist. If you do not come in for your appointment, or break your appointment without sufficient notice, a $25.00 per hour broken appointment fee will be applied to your account and you will be required to pre-pay for your next appointment. Our hours are M 7-5, Tu 7-5, W 8-6

Fees
The fees for quality dental treatment are based on the treatment rendered and the time needed to complete the treatment. Our office believes that the fees are a fair representation of the standard of care we provide and in-step with the industry standard. We will review with you a detailed printed estimate of the total fees for your treatment.

Payments
1. Payment is due prior to receiving dental treatment.
2. We accept Cash, Personal Checks, Visa, MasterCard, Discover and American Express.
3. We offer a 6 to 12 month payment plan through Care Credit to qualified patients.

Insurance
As a courtesy to you and for your convenience we will bill your insurance company for treatment rendered, provided we have current and accurate benefit coverage information. Please understand that your dental benefit program is a contract between you, your employer and the insurance company. We do not have a contract with your insurance company and we do not know the details of what your insurance plan covers. You hold the contract. Therefore, you are responsible to know what your plan covers and you are responsible for any balance on your account. We will expect you to pay your deductible and any out-of-pocket portions prior to receiving dental treatment. In the event that your insurance company overpays, we will gladly refund you promptly. If your insurance carrier does not pay for the remaining treatment balance in full within 60 days, you will be sent a statement from us, and you will be responsible for your account balance.

Finance Charge
Even though we encourage patients to maintain a zero-balance account, in the event your account is not paid in full, a service fee will be incurred on any unpaid balance that is older than 60 days. The service fee will be a minimum of two dollars or 1 ½ % per month (18 percent annually) of the unpaid balance whichever is greater.

Prepayment Discounts
We ask that you pay for your next appointment at the time that you set the appointment. When you pre-pay for your appointment you will receive a 5% discount if paid by cash, check, or credit card.

Returned Checks
There is a $25.00 fee for any returned checks.

____ ________________

Responsible Party Signature Date

Smile Assessment

Previous dentist:____________________ Date of last visit:_________________________

To help us make your visit more comfortable, please let us know the following about your previous dental visits
What you liked most:____
What you liked least:____

How would you rate your smile (1=worst, 10=best) : 1 2 3 4 5 6 7 8 9 10
How would you rate the color of your teeth (1=worst, 10=best) : 1 2 3 4 5 6 7 8 9 10
What would you like to change if interested?

____

What do you value in a dental office?

- ☐ Cosmetic: how your teeth look.
- ☐ Function: an ability to enjoy your favorite food and drinks.
- ☐ Comfort: not being in pain or having tooth or gum sensitivity.
- ☐ Longevity: to have your natural teeth for lifetime.

What is the most important objection or obstacle you have about visiting a dentist?

- ☐ No objection/obstacle - I come faithfully every 6 months and value my dental health.
- ☐ Fear - I have a fear of pain, noises, environment and/or past experiences.
- ☐ Time - I have a tight & busy schedule. I value convenient times.
- ☐ Have NOT had a sense of urgency - Nothing really hurts or I am able to live with pain.
- ☐ No trust - I did not feel the treatment made sense.

YES	NO	Patient Dental History
☐	☐	Do your gums bleed when you brush?
☐	☐	Do you feel pain in any of your teeth?
☐	☐	Are you interested in straight teeth in only 6 months?
☐	☐	Are you interested in whiter teeth in 2 hours?
☐	☐	Do you grind your teeth at night? Do you have joint /jaw pain?
☐	☐	Are you interested in replacing silver fillings with tooth colored ones?