

# Welcome

We are pleased to welcome you to our practice.  
Please take a few minutes to fill out this form as completely as you can. If you have questions,  
we'll be glad to help you. We look forward to working with you in maintaining your dental health.

## PATIENT INFORMATION

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Last Name First Name Middle Initial

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Email \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced

Patient Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Notify in case of emergency \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Business Email \_\_\_\_\_

## PRIMARY INSURANCE

Person Responsible for Account \_\_\_\_\_  
Last Name First Name Middle Initial

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Email \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber's # \_\_\_\_\_

Name(s) of other dependents under this plan \_\_\_\_\_

## ADDITIONAL INSURANCE

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Subscriber Employed by \_\_\_\_\_ Business Email \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_ Insurance Email \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber's # \_\_\_\_\_

Name(s) of other dependents under this plan \_\_\_\_\_

Please complete both sides.

What would you like us to do today? \_\_\_\_\_

Are you in dental discomfort today? \_\_\_\_\_

Former Dentist \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Dentist's Email \_\_\_\_\_

Date of last dental care \_\_\_\_\_ Date of last X-rays \_\_\_\_\_

Check Y for yes or N for no if you have or have not had the following:

- Y  N Bad breath       Y  N Food collection between teeth       Y  N Periodontal treatment       Y  N Sensitivity to sweets
- Y  N Bleeding gums       Y  N Grinding or clenching teeth       Y  N Sensitivity to cold       Y  N Sensitivity when biting
- Y  N Clicking or popping jaw       Y  N Loose teeth or broken fillings       Y  N Sensitivity to hot       Y  N Sores or growths in mouth

How often do you brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

How do you feel about the appearance of your teeth? \_\_\_\_\_

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?  Y  N

## MEDICAL HISTORY

Physician's name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Physician's Email \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you had any serious illnesses or operations?  Y  N If yes, describe \_\_\_\_\_

Are you currently under physician care?  Y  N If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  Y  N If yes, give approximate dates \_\_\_\_\_

Have you ever taken Fen-Phen/Redux?  Y  N

Women: Are you pregnant?  Y  N      Nursing?  Y  N      Taking birth control pills?  Y  N

Check Y for yes or N for no if you have or have not had any of the following:

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Positive       | <input type="checkbox"/> Y <input type="checkbox"/> N Cough, persistent            | <input type="checkbox"/> Y <input type="checkbox"/> N Jaw pain                        | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles                       |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anaphylaxis             | <input type="checkbox"/> Y <input type="checkbox"/> N Cough up blood               | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney disease or malfunction   | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath            |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia                  | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes                     | <input type="checkbox"/> Y <input type="checkbox"/> N Liver disease                   | <input type="checkbox"/> Y <input type="checkbox"/> N Skin rash                      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis, Rheumatism   | <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy                     | <input type="checkbox"/> Y <input type="checkbox"/> N Material allergies              | <input type="checkbox"/> Y <input type="checkbox"/> N Spina Bifida                   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial heart valves | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting                     | <input type="checkbox"/> Y <input type="checkbox"/> N (latex, wool, metal, chemicals) | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke                         |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial joints       | <input type="checkbox"/> Y <input type="checkbox"/> N Food allergies               | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral valve prolapse           | <input type="checkbox"/> Y <input type="checkbox"/> N Surgical implant               |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma                  | <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma                     | <input type="checkbox"/> Y <input type="checkbox"/> N Nervous problems                | <input type="checkbox"/> Y <input type="checkbox"/> N Swelling of feet or ankles     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Atopic (allergy prone)  | <input type="checkbox"/> Y <input type="checkbox"/> N Headaches                    | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker/Heart surgery         | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease or malfunction |
| <input type="checkbox"/> Y <input type="checkbox"/> N Back problems           | <input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur                 | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric care                | <input type="checkbox"/> Y <input type="checkbox"/> N Tobacco habit                  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood disease           | <input type="checkbox"/> Y <input type="checkbox"/> N Heart problems               | <input type="checkbox"/> Y <input type="checkbox"/> N Rapid weight gain or loss       | <input type="checkbox"/> Y <input type="checkbox"/> N Tonsillitis                    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer                  | Describe _____   | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation treatment             | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis                   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemical dependency     | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/Abnormal bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Respiratory disease             | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcer/Colitis                  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy            | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes                       | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic fever                 | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal disease               |
| <input type="checkbox"/> Y <input type="checkbox"/> N Circulatory problems    | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis                    | <input type="checkbox"/> Y <input type="checkbox"/> N Scarlet fever                   |  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cortisone treatments    | <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure          |   |  |

List medications you are currently taking, if any: \_\_\_\_\_

List drug allergies, if any: \_\_\_\_\_

## AUTHORIZATION

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Payment is due in full at time of treatment unless prior arrangements have been approved.



## ARIZONA STATE DENTAL ASSOCIATION

### FACTS YOU SHOULD KNOW ABOUT DENTAL INSURANCE

Dental insurance is rapidly playing a larger and larger role in helping people obtain dental treatment. Since we strongly feel our patients deserve the best possible care we can provide, and in an effort to maintain the high quality of care, we would like to share some facts about dental insurance with you.

Fact #1 Dental insurance is NOT meant to be a PAY-ALL, it is only meant to assist you in the payment of your dental care.

Fact #2 Many routine dental services are NOT covered by insurance carriers, although they may be necessary.

Fact #3 Many plans state that you will be covered "up to 50%, 80% or 100%." In spite of what you're told, we've found in actuality that many plans may cover less than that depending on their established usual and customary fees. The benefits your plan pays is largely determined by how much your employer/union paid for the plan. The less he paid for the insurance, the less you'll receive.

Fact #4 Insurance Companies' established "Usual and Customary" fee schedules may or may not have an accurate relationship to what "usual and customary" fees are for a given area. It has been the experience of some dentists that some insurance companies tell their insured that "fees are above the usual and customary fees"—rather than saying to them that "our benefits are low". This may be so because there are various ways and calculations by which the company establishes their usual and customary fees. Therefore, it is possible that different insurance companies will have different usual and customary fees for the same geographical area. The dentist's fees may be within one company's, and not within another company's, usual and customary fees. Remember you only get back what your employer/union puts in, less the profits of the insurance company.

Please do not be hesitant in asking us any questions about our office policies. We want you to be comfortable in dealing with these matters and we urge you to consult us if you have any questions regarding our services and/or fees. We will do all we can to assure you of maximum benefits.

If you have any questions regarding your insurance, we can send in a predetermination to find out exact benefits or you can contact your company regarding the specifics and details on the plan it is conducting in your behalf.

I have read about and understand my insurance limitations. I also understand that I am financially responsible for my dental treatment.

\_\_\_\_\_  
Patient/Parent/Insured

*Policy adopted by the Arizona State Dental Association House of Delegates, May 16, 1986  
Dental Care Resolution-H(1985-1986)-19: "Facts You Should Know About Dental Insurance"*

## C O N S E N T T O D E N T A L T R E A T M E N T

1. I request and authorize above listed provider of service, and/or such other persons as he/she may appoint, to perform or assist in the performance of the dental treatment or procedures indicated below, which consists of but is not limited to: treatment name. I understand that the purpose of this procedure is to remove decay restore optimal function and periodontal health.

I understand that there have been no guarantees given or implied of any sort by anyone as to the results that may be obtained.

2. I understand that any recommended treatment or procedure involves the following risks: possibility of root canal therapy.
3. As an alternative to this therapy, I may elect to non treatment.
4. I also understand that failure to treat this condition will result in non-treated outcome, with the possibility of eventual tooth or bone loss.
5. Further, it is understood that unforeseen conditions or circumstances may arise during the course of the above described procedure or alternate treatment. Therefore, I consent to and authorize the performance of any care, procedure, or treatment not specified above that the dentist believes necessary or advisable as a result of these unforeseen events or conditions.
6. I consent to the administration of any anesthetic that the dentist (or his appointees) deems necessary to provide proper treatment.
7. I understand that there are risks involved with the administration of anesthesia. The alternative to the use of these anesthetics is no anesthesia.
8. I will be given an opportunity to refuse to consent to any and all treatment or procedures specified in this form and during the consultation. I have indicated my exclusions by drawing a line through the objectionable word(s), sentence(s), or paragraph(s), and writing my initials next to the portion to which I refuse to consent. I am also free to indicate at the end of this form anything not mentioned herein, but to which I refuse to consent.

**I certify that I have read and understand the above. I accept all risk of, if any, in hope of obtaining the desired beneficial results. I acknowledge that the dentist has explained all of the above to me in a manner to allow me to comprehend the consequences of my actions. Any questions about this treatment plan and its attendant risks have been answered fully and to my complete satisfaction.**

\_\_\_\_\_  
Patient or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

# HEALTHY SMILES DENTAL GROUP

{NAME OF PRACTICE}

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

\* You May Refuse to Sign This Acknowledgement\*

I, \_\_\_\_\_, have received a copy of this  
office's Notice of Privacy Practices.

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but  
acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# HEALTHY SMILES DENTAL GROUP

{NAME OF PRACTICE}

## NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

### OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04 / 14 / 03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

### USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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### PATIENT RIGHTS

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.\_\_\_\_\_ for each page, \$ 20 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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### QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: SHARRI

Telephone: (480) 892-9190 Fax: (480) 545-9671

E-mail: \_\_\_\_\_

Address: 3333 EAST BASELINE  
GILBERT, ARIZONA 85234

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