Patient Information

Patient Name: _____ Date: _____
Last, First MI

Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

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

E mail address:_____

Address: _____
Street Apartment #

_____
City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? _____

In case of an emergency who may we call?

Name: _____ Relationship: _____ Phone: _____

Employment Information

Employer Name: _____ Occupation: _____

Employer Phone:

Insurance Information

Primary
Name of Insured: _____
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary
Name of Insured: _____
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Medical
Name of Insured: _____
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Health Information

Date of Last Dental Visit: _____ Reason for your visit today: _____

Have you ever had any of the following? ***Please select one.***

Y	N		Y	N		Y	N	
□	□	AIDS	□	□	Glaucoma	□	□	Osteoporosis
□	□	Allergies	□	□	Grind or Clench Teeth	□	□	Pacemaker
□	□	Anemia	□	□	Hay Fever	□	□	Are you currently pregnant or (any chance of) Due Date:_____
□	□	Angina	□	□	Heart Attack	□	□	Are you currently nursing?
□	□	Arthritis	□	□	Heart Surgery	□	□	Radiation Treatment
□	□	Artificial Joints/Implants	□	□	Heart Palpitations	□	□	Respiratory Problems
□	□	Asthma	□	□	Heart Valve	□	□	Rheumatic Fever
□	□	Blood Disease	□	□	Head Injuries	□	□	Rheumatism
□	□	Blood Transfusion	□	□	Heart Disease	□	□	Seizures/Convulsions
□	□	Cancer	□	□	Heart Murmur	□	□	Sinus Problems
□	□	Chronic Cough	□	□	Hepatitis	□	□	Stomach Problems
□	□	Clicking/Popping of Jaw	□	□	High Blood Pressure	□	□	Stroke
□	□	Depressed Immune System	□	□	HIV	□	□	Thyroid Disease
□	□	Diabetes	□	□	Jaundice	□	□	Tuberculosis
□	□	Dizziness	□	□	Kidney Disease	□	□	Tumors
□	□	Emphysema	□	□	Liver Disease	□	□	Ulcers
□	□	Epilepsy	□	□	Lung Disease	□	□	Venereal Disease
□	□	Excessive Bleeding	□	□	Mental Disorders	□	□	Other:_____
□	□	Fainting	□	□	Nervous Disorders	□	□	

Do you need to PreMedicate prior to Dental Appointment? ☐ Yes ☐ No _____

Are you using any of the following? Please check those that apply:

□ Antibiotics □ Blood Thinners □ Aspirin / Motrin, Aleve □ Tranquilizers
□ High Blood Pressure □ Steroids/ Cortisone □ Ibuprofen □ Insulin/ Anti-Diabetic Drugs
□ Medication □ Heart Drugs (Digitalis/Inderal etc.) □ Phen Phen

Please list any other medications you are taking including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals:_____
_____
_____

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

□ Biosphosphnates (for Oseoporosis/Cancer) □ Fosamax, Actonel, Boniva, Aredia, or Zometa □ Phen-Phen

Are you allergic to or have you had an adverse reaction to any of the following? Please check those that apply:

□ Local Anesthesia/ Novocaine □ Penicillin / Antibiotics □ Sedatives / Barbiturates □ Aspirin/ Ibuprofen
□ Codeine/ Pain killers □ Latex/Rubber □ OTHER: _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Do you smoke or chew Tobacco products? ☐ Yes ☐ No
  If yes, How much per day: _____
- Have you ever had past history of Alcohol, Chemical dependency or Emotional disorder? ☐ Yes ☐ No
- Have you or an immediate family member ever had any problems associated with intravenous anesthesia ☐ Yes ☐ No
  If yes, please explain: _____
- 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
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- If you are using oral contraceptives, it is important to understand that antibiotics (and some other medications) may Interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control.
- Do you wish to talk to the doctor privately about anything? ☐ 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.

Patient Signature _____ Date_____

Dentist Signature _____ Date _____

Consent for Services

In the event that I was to swallow or aspirate a dental restoration such as a filling, crown, onlay, inlay, veneer, bridge, and implant etc… I will agree to have an x-ray taken at a healthcare facility of my choice to rule out any possible complications. Dental Specialty Associates has agreed to pay for this procedure. If I chose to decline the x-ray, I agree to sign a waiver and will not hold Dental Specialty Associates liable for any and all future health related issues caused by the event.

If your doctor prescribes any medication for you, understand it that may cause drowsiness and you should not drive, operate heavy machinery, or sign important legal documents while taking that drug. Please consult your doctor if you have any questions.

Dental Specialty Associates will not be held responsible for any valuables brought into the operating room suites. Please arrange for these items to be cared for by someone else while you are being treated.

Thank you for choosing Dental Specialty Associates, this policy was designed to ensure that all finances (payments due) are recovered, which will allow us to continue to provide the best quality dental care for our patients. It is important to keep patient/office relationship strong, therefore it is important to assure payment for services is a smooth transaction by making it as simple and straight forward as possible.

Please read the following carefully, initial each statement and sign below. Thank you.

Initials

____ Payment is expected at the time services are provided. If patient has insurance, the estimated patient portion is due at the time of service. Any payment arrangement must be made in advanced.

____ DSA allows 45 days for insurance company to pay the insurance estimated portion. If insurance has not fully paid a claim after allowed time, patient is expected to pay the remaining portion.

____ As a courtesy to our valued patients, DSA verifies patient's benefits and generates claim charges to insurance company. Information received is NOT a guarantee of payment, benefits received are used to estimate patient financial portion.

____ Patient understands that any costs incurred during treatment are patient responsibility. Insurance may help pay for a portion of treatment. Treatment quoted is an ESTIMATE only. Patient will be responsible for any unpaid fees by insurance company.

____ A 1.8% interest may applied to the balance and additional costs of balance being sent to a collection agency (30% or greater) will be applied to the balance. Patient will be responsible for any legal fees.

____ Due to a high demand for appointment, missed appointments prevent us from scheduling appropriately and keep others in needs of urgent care from being seen. A $50.00 fee will be assed for all missed appointments not cancelled with 48 hour notice.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

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

I hereby acknowledge that I have reviewed a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding the Notice.

Patient Printed Name: _____

Patient Signature: _____ Patient Date: _____

Notice of Privacy Practices for Protected Health Information

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!

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of uses of your health information for treatment purposes:
A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

Example of use of your health information for payment purposes:
We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:
We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights
The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Request that you be allowed to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact **Office Manager,** in person or in writing, during normal hours. She will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities
The practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint
If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact **Office Manager (480)633-9977.**

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to our **Office Manager.** You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services whose street address and phone number is: **200 Independence Ave., S.W. Washington, DC 20201 (877) 696-6775.**

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Disclosures and Uses

Notification
Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family
Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA)
We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation
If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health
As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect
We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions
If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement
We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight
Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses
Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

OPTIONAL/ADDITIONAL Uses and Disclosures

An example would be: If your practice participates with drug research, then you would need to include the first item listed below in your Notice of Privacy Practices.

Research
- We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Disaster Relief
- We may use and disclose your protected health information to assist in disaster relief efforts.

Funeral Directors/Coroners
- We may disclose your protected health information to funeral directors or coroners consistent with applicable law to allow them to carry out their duties.

Organ Procurement Organizations
- Consistent with applicable law, we may disclose your protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing
- We may contact you to provide you with information about treatment alternatives, or with information about other health-related benefits and services that may be of interest to you.

Fund Raising
- We may contact you as part of a fund raising effort.

For Specialized Governmental Functions
- We may disclose your protected health information for specialized government functions as authorized by law, such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.