



# Office Policies

## Notice of Privacy Practices & HIPAA

A laminated copy of our office Notice of Privacy Practices and HIPAA is available in our office. You have the right to read our Notice before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this consent. Upon your request we will be happy to provide you with your own personal copy of our Privacy Practices.

HIPAA regulations authorize the release of PHI for the purpose of treatment, obtaining payment from Third party payers, and the standard healthcare operations. Other than those releases authorized by HIPAA, PHI will only be released to persons listed on this authorization. If you choose not to authorize any family members or friends, we will not be able to release any information to anyone other than the patient.

I hereby authorize Anantuni Family Dental, PC to release my patient health information as described below:

<hr/>	
Authorized Individual Name	Relationship
<b>Type of Information allowed to Disclose:</b>	<b>Type of Disclosure:</b>
<input type="checkbox"/> Dental Records <input type="checkbox"/> Financial	<input type="checkbox"/> Phone <input type="checkbox"/> Person <input type="checkbox"/> Email

I understand that I am not required to sign this authorization. I acknowledge that I have read or received a copy of this office's Notice of Privacy Practices and that Anantuni Family Dental abides by the HIPAA Law and will protect the privacy of my personal information.

<hr/>	<hr/>	<hr/>
Patient Name (Print)	Signature or Patient or Guardian	Date

## Authorization for Signature on File

I (name of patient), \_\_\_\_\_ and/or (name of insured) \_\_\_\_\_, hereby authorize Anantuni Family Dental to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my insurer. I hereby authorize payment of dental benefits otherwise payable to me directly to the office above. I agree to be responsible for all charges for dental services whether or not paid by my insurance. I authorize the release of any information relating to this claim to obtain payment. I authorize the use of this signature on all insurance submissions.

<hr/>	<hr/>
Signature of Patient	Date

This authorization will be valid from this date and shall expire in one year.

## Financial Policy

Thank you for choosing Anantuni Family Dental to serve your dental care needs. We provide high-quality dental care to our patients and are committed to your treatment being successful. Please understand that your financial obligation is considered a part of your treatment. In the interest of good dental care practice, it is desirable to establish a credit policy to avoid misunderstandings. To assist our patients, we offer the following methods for taking care of their account in our office.

- On your first visit we expect you to supply our office with your insurance information and a photo ID. If any changes should occur during the time you are a patient, it is your responsibility to inform our office with any changes. Our office will not be responsible for claims submitted to insurance companies by which you are no longer covered.
- As a **courtesy**, we will gladly bill your insurance. While we accept most insurance plans, and are happy to aid in submission of your claims, it is your responsibility to read your policy and understand that this is a contract between your employer, your insurance company and yourself. Please be aware of some and perhaps all of the services rendered may be not covered by your individual plan and you are ultimately responsible for the payment on the account.
- We cannot accept responsibility for collecting an insurance claim after 60 days or for negotiating a disputed claim. If no payment is received on an account after two monthly statements our office will make every effort to contact the responsible party. If the party responsible cannot be reached, a third bill will be sent indicating that **“This will be the final notice for payment”**. If the party fails to contact our office after receiving such notice, the account will be sent to a collection agency.
- We ask that you either pay your estimated patient portion of the bill at the time of service, or that a suitable written financial arrangement be reached at the time of service. We accept cash, all major credit cards, personal checks, and financing from Care Credit. For all checks returned due to **non-sufficient funds**, there will be a \$35 fee added to your account.
- If an insurance company pays more than anticipated creating a credit for the patient, we are happy to either refund the patient or leave the credit on the account to be applied toward future treatment.
- The original dental record, including but not limited to treatment notes, x-rays, study models are the property of Anantuni Family Dental. These originals will not be released to patients or other healthcare providers, without written request. I understand that a \$25 fee may be applied to my account for duplication of my dental records and x-rays.

## Delinquent Accounts

On occasion, after repeated attempts to collect a balance due, we may need to turn an account over to a collections agency. Should this occur, it is agreed that the financially responsible party listed below shall pay all finance charges, collection cost, attorney fees and any other costs that may be incurred to enforce collection of any amount outstanding. In addition, a collection fee based on the balance of the account will be added.

## Failed or Cancelled Appointments

If an appointment has been reserved for you, we kindly ask that patients give us 48 hour notice for cancellations; otherwise, we reserve the right to charge a minimum of **\$50 per hour** of scheduled appointment. If the appointment is with a specialist, the minimum fee is **\$75 an hour**. We will only offer appointments **SAME DAY** to patients who fail multiple appointments without having given us proper notice.

I confirm that I have read and understand this form or it was read to me and all of my questions have been answered to my satisfaction.

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Patient Name

Signature of Patient or Guardian

Date



5590 W Chandler Blvd #1  
Chandler, AZ 85226  
P: 480-821-4000  
F: 480-893-7764

## Welcome To Our Office!

To help us meet all your healthcare needs, please fill out this form completely in ink.  
If you have any questions or need assistance, please ask us and we will be happy to help.

### Patient Information (Confidential)

Name \_\_\_\_\_ Date \_\_\_\_\_  
Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell # \_\_\_\_\_  
Address \_\_\_\_\_ Apt# \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Email \_\_\_\_\_ Driver's License # \_\_\_\_\_  
When confirming appointments how do you prefer to be contacted?  Phone  Email  Text Message  
Patient's or Parent's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

### How did you hear about our office? (Check All That Apply)

Google  Yelp  Website  Insurance Company  Drive By  ZocDoc  Facebook  
 Friend \_\_\_\_\_  Patient \_\_\_\_\_

### Responsible Party

Responsible Party for this Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Phone # \_\_\_\_\_ Is this Person Currently a Patient in our Office?  Yes  No

### Emergency Contact (Please list TWO different contacts)

Primary Contact: \_\_\_\_\_ Phone# \_\_\_\_\_ Relation: \_\_\_\_\_  
Secondary Contact: \_\_\_\_\_ Phone# \_\_\_\_\_ Relation: \_\_\_\_\_

### Insurance Information (policy holder)

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ ID# \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Phone # \_\_\_\_\_

### Secondary Insurance

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ ID# \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Phone # \_\_\_\_\_

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## Patient Medical History

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

	Yes	No
1. Are you under medical treatment now?	<input type="checkbox"/>	<input type="checkbox"/>

2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
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If yes, please explain \_\_\_\_\_

3. Are you taking any medication(s) including non-prescription medicine?	<input type="checkbox"/>	<input type="checkbox"/>
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If yes, what medications are you taking? \_\_\_\_\_

4. Are you currently taking or have you ever taken osteoporosis medications in the past?	<input type="checkbox"/>	<input type="checkbox"/>
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If so, how long? \_\_\_\_\_ Which ones? \_\_\_\_\_

5. Any current use or history of use of tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
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If so, how long? \_\_\_\_\_ What type and amount? \_\_\_\_\_

6. Any current use or history of use of alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
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If so, how long? \_\_\_\_\_ How frequent and amount? \_\_\_\_\_

7. Do you use or have history of use of controlled substances or recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>
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If yes, which ones (including medical marijuana) and how often? \_\_\_\_\_

	Yes	No		Yes	No
8. <b>Are You Allergic to:</b>					
Local Anesthetics (e.g. Novocain)	<input type="checkbox"/>	<input type="checkbox"/>	Iodine	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>	Ibuprofen	<input type="checkbox"/>	<input type="checkbox"/>
Other Antibiotics _____	<input type="checkbox"/>	<input type="checkbox"/>	Codeine	<input type="checkbox"/>	<input type="checkbox"/>
Latex Rubber	<input type="checkbox"/>	<input type="checkbox"/>	Any Metals (e.g. nickel, mercury, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Sedatives	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
9. <b>Women Only:</b>		

a) Are you pregnant or think you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
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When are you due? \_\_\_\_\_ Who is your OB/GYN? \_\_\_\_\_ Phone# \_\_\_\_\_

b) Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
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c) Are you taking oral contraceptives?	<input type="checkbox"/>	<input type="checkbox"/>
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10. Do you have or have you had any of the following?								
	Yes	No		Yes	No		Yes	No
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema/COPD	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Type _____			Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	When _____			Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
When? _____			Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Type _____			When _____		
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Neck/Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	When _____		
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Sight Impaired	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Impaired	<input type="checkbox"/>	<input type="checkbox"/>
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	STD's	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		

## Patient Dental History

Name of Previous Dentist \_\_\_\_\_ Date of Last Exam/Cleaning \_\_\_\_\_

- |  | Yes                      | No                          |
|--|--------------------------|-----------------------------|
| 1. Do you like your smile?<br>What would you change? _____   | <input type="checkbox"/> | <input type="checkbox"/> 1  |
| 2. Do your gums bleed while brushing or flossing?  | <input type="checkbox"/> | <input type="checkbox"/> 2  |
| 3. Are your teeth sensitive to hot or cold liquids/foods?  | <input type="checkbox"/> | <input type="checkbox"/> 3  |
| 4. Are your teeth sensitive to sweet or sour liquids/foods?  | <input type="checkbox"/> | <input type="checkbox"/> 4  |
| 5. Do you feel pain on any of your teeth?  | <input type="checkbox"/> | <input type="checkbox"/> 5  |
| 6. Do you have any sores or lumps in or near your mouth?   | <input type="checkbox"/> | <input type="checkbox"/> 6  |
| 7. Have you had any head, neck or jaw injuries?  | <input type="checkbox"/> | <input type="checkbox"/> 7  |
| 8. Have you ever experienced any of the following problems in your jaw?  | <input type="checkbox"/> | <input type="checkbox"/> 8  |
| A. Clicking  | <input type="checkbox"/> | <input type="checkbox"/> A  |
| B. Pain (joint, ear, side of face)   | <input type="checkbox"/> | <input type="checkbox"/> B  |
| C. Difficulty in opening or closing  | <input type="checkbox"/> | <input type="checkbox"/> C  |
| D. Difficulty in chewing   | <input type="checkbox"/> | <input type="checkbox"/> D  |
| 9. Do you have frequent headaches or migraines?  | <input type="checkbox"/> | <input type="checkbox"/> 9  |
| 10. Do you clench or grind your teeth?   | <input type="checkbox"/> | <input type="checkbox"/> 10 |
| 11. Do you wear an Oral Appliance? <input type="checkbox"/> CPAP <input type="checkbox"/> Occlusal/Night guard <input type="checkbox"/> Sports Guard |                          |                             |
| 12. Have you ever been diagnosed with sleep apnea?   | <input type="checkbox"/> | <input type="checkbox"/> 11 |
| 13. Do you snore?  | <input type="checkbox"/> | <input type="checkbox"/> 12 |
| 14. Do you bite your lips or cheeks frequently?  | <input type="checkbox"/> | <input type="checkbox"/> 13 |
| 15. Have you ever had any difficult extractions in the past?   | <input type="checkbox"/> | <input type="checkbox"/> 14 |
| 16. Have you ever had any prolonged bleeding following extractions?  | <input type="checkbox"/> | <input type="checkbox"/> 15 |
| 17. Have you had any orthodontic treatment?  | <input type="checkbox"/> | <input type="checkbox"/> 16 |
| 18. Do you wear dentures or partials? If yes, date of placement _____  | <input type="checkbox"/> | <input type="checkbox"/> 17 |
| 19. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? <input type="checkbox"/>                             | <input type="checkbox"/> | <input type="checkbox"/> 18 |

**\*FOR OFFICE USE ONLY:**      BP: \_\_\_\_\_ P: \_\_\_\_\_

### Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I agree to be responsible for payment of all service rendered on my behalf of my dependents.

Print Name of Patient \_\_\_\_\_ Preferred Name \_\_\_\_\_

Signature of Patient (Parent of Minor) \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_