PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name: _____
Last First MI (Preferred)

Birthdate: _____ SS #: _____ Gender: ☐ M ☐ F Married: ☐ Y ☐ N

Wireless Phone: _____ Work Phone: _____

Email: _____

Preferred Contact Method: ☐ Wireless Phone ☐ Text

Preferred Appointment Time:

Monday: ☐ Morning ☐ Afternoon ☐ Evening

Tuesday: ☐ Morning ☐ Afternoon ☐ Evening

Wednesday: ☐ Morning ☐ Afternoon ☐ Evening

Friday: ☐ Morning ☐ Afternoon

How did you hear about us?

_____

(If someone referred you here, please enter their name so we can thank them.)

ADDRESS AND HOME PHONE

Check box if same for entire family: ☐

Address: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

INSURANCE POLICY 1

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: _____ Subscriber ID #: _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group #: _____

Please present insurance card to receptionist.

INSURANCE POLICY 2

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: _____ Subscriber ID #: _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group #: _____

MEDICAL HISTORY

Last Name: _____ First Name: _____ Birthdate: _____

Name of Medical Provider: _____ City/State: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

List all medications that you are now taking:
EXISTING PATIENTS Check the box next to any medication no longer being taken.

1. ☐ _____
2. ☐ _____
3. ☐ _____
4. ☐ _____
5. ☐ _____
6. ☐ _____
7. ☐ _____
8. ☐ _____
9. ☐ _____
10. ☐ _____

In the last twelve years, have you ever taken or are you now taking any of these following medications:

- ☐ Actonel
- ☐ Aredia
- ☐ Bonefos
- ☐ Didronel
- ☐ Fosamax
- ☐ Ostac
- ☐ Skelid
- ☐ Zometa
- ☐ Risedronate
- ☐ Ibandronate
- ☐ Etidronate
- ☐ Alendronate
- ☐ Clodronate
- ☐ Tiludronate
- ☐ Zoledronic Acid

Are you allergic to any of the following?

Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Iodine
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Penicillin
☐	☐	Ibuprofen	☐	☐	Sulfa

Other allergies not listed above:

_____

Do you have any of the following medical conditions?

Y	N		Y	N	
☐	☐	Asthma	☐	☐	Kidney Disease
☐	☐	Bleeding Problems	☐	☐	Liver Disease
☐	☐	Cancer	☐	☐	Pregnancy
☐	☐	Diabetes	☐	☐	Psychiatric Treatment
☐	☐	Heart Murmur	☐	☐	Rheumatic Fever
☐	☐	Heart Trouble	☐	☐	Sinus Trouble
☐	☐	High Blood Pressure	☐	☐	Stroke
☐	☐	Joint Replacement	☐	☐	Ulcers

Other conditions not listed above:

_____

Patient/Guardian Signature
Date:

_____

FINANCIAL AGREEMENT

Last Name: _____ First Name: _____ Birthdate: _____

FINANCIAL INFORMATION

Person responsible for this account: _____ Relationship: _____

Address: _____ Phone No.: _____

Payment Options: ☐ Cash ☐ MasterCard ☐ Visa ☐ Discover
☐ American Express ☐ CareCredit ☐ Denefits

- For my convenience, this office may release my information to my insurance company, and receive payment directly from them.
- I understand that the payment is due at the time of service.
- If sent to collections, I agree to pay all related fees and court costs.
- Treatment plans are based on insurance estimates, but if they do not pay as expected, I will still be responsible.

- I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due.
- Returned Checks: There is a $25.00 fee for any returned checks.
- I will pay a fee for appointments broken without 48 hours notice.
- Third party financing monthly payment options are available.

Patient/Guardian Signature
Date:

_____

GREAT SMILE
FAMILY DENTISTRY

Last-minute Cancellation / No-show Policy

We kindly request that you provide us with a minimum **48 hours** notice. Failure to provide adequate notice or any no-shows for appointments will result in a **late cancellation fee of $75.**

The cancellation fee reflects the costs associated with reserving time and resources for your appointment, as well as the impact it has on our ability to accommodate other patients.

We understand that unforeseen circumstances can arise, and we will exercise compassion and flexibility in addressing genuine emergencies or unavoidable situations on a case-by-case basis.

Patient Name:

Signature:

Date:

Smile Assessment

Previous dentist:_____ Date of last visit:_____

Reason for today's visit: _____
Are you in pain? _____
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 a 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.

Patient Dental History

- ☐ Do you have an unusual reaction to dental injections?
- ☐ 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?

- ☐ Do you have dental anxiety or fear?
- ☐ Are you interested in receiving laughing gas (nitrous oxide) to help with your anxiety and keep you comfortable?

HIPAA Notice of Privacy Practices

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.

Tr eatment: 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 **September 01, 2017.**

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_____