Tempe Dental Care

5801 S. McClintock Dr. Suite 101
Tempe, AZ 85283

Thank you for visiting Tempe Dental Care. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information:

Name _____
LAST FIRST MIDDLE INITIAL PREFERRED NAME

Address _____
STREET APT #

_____
CITY STATE ZIP

Birth Date _____ ❑ Male ❑ Female

Employer _____

Height _____ Weight _____ ❑ Married ❑ Single ❑ Other

Phone: Home (_____)_____ Social Security # _____

Work (_____)_____

Cell (_____)_____ Email _____

Emergency Contact: Name _____ Phone (_____)_____

If Patient Is Under 18 Years Old:

Responsible Party _____ Phone: (_____)_____ Relationship to Patient _____

How Did You Hear About Us?: ❑ Phone Book ❑ Google ❑ Yahoo ❑ Yelp ❑ Walk in/Drive by ❑ Insurance ❑ Mailer

Referred By: _____ Other: _____

Insurance:

Primary Dental Carrier

Insurance Co Name: _____ Phone #: _____

Insured's Name: _____ Birth Date: _____ ID#: _____

Insured's Employer: _____ Group #: _____

Relationship to Patient: _____

Secondary Dental Carrier

Insurance Co Name: _____ Phone #: _____

Insured's Name: _____ Birth Date: _____ ID#: _____

Insured's Employer: _____ Group #: _____

Relationship to Patient: _____

The information on this page is correct to the best of my knowledge: (SIGN AND DATE)

X_____ _____
PATIENT OR PARENT/GUARDIAN SIGNATURE **DATE**

PATIENT NAME: _____

Health History

Primary Physician's Name_____ Physician's Phone _____

Have you had a serious illness or operation? Y ❑ N ❑

If yes, please describe:

_____

Are you currently under physician care? Y ❑ N ❑

If yes, please describe:

_____

Please check those conditions that have ever applied to you

Conditions

- ❑ Abnormal Bleeding
- ❑ Alcohol Abuse
- ❑ Allergies
- ❑ Anemia
- ❑ Angina Pectoris
- ❑ Arthritis
- ❑ **Artificial Heart Valve**
- ❑ Asthma
- ❑ Blood Transfusion
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Colitis
- ❑ **Congenital Heart Defect**
- ❑ Diabetes
- ❑ Difficulty Breathing
- ❑ Drug Abuse
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Facial Surgery
- ❑ Fainting Spells
- ❑ Fever Blisters
- ❑ Frequent Headaches
- ❑ Glaucoma
- ❑ HIV+ Aids
- ❑ **Heart Attack**
- ❑ **Joint Replacement**
- ❑ Heart Murmur
- ❑ Heart Surgery
- ❑ Hemophilia
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ High Blood Pressure
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Pace Maker
- ❑ Psychiatric Problems
- ❑ Radiation Therapy
- ❑ **Rheumatic Fever**
- ❑ Seizures
- ❑ Sexually Transmitted Disease
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Problems
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Ulcers

Allergies

- ❑ Aspirin
- ❑ Codeine
- ❑ Erythromycin
- ❑ Latex
- ❑ Metals
- ❑ Penicillin
- ❑ Sulfa
- ❑ Morphine

Other Allergies:

_____

Y	N	
❑	❑	Do you Smoke or use Tobacco?

Women Only

Y	N	
❑	❑	Are you taking Birth Control Pills?
❑	❑	**Are you pregnant? If yes, # of weeks** _____
❑	❑	Are you nursing?

Please list any medications you are currently taking:

_____

_____

Have you EVER taken any bisphosphonates? (e.g. Fosomax, Actonel) Y ( ) N ( )

Treatment Authorization: (SIGN AND DATE)

The information on this page is correct to the best of my knowledge. I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

X_____ _____

PATIENT OR PARENT/GUARDIAN SIGNATURE **DATE**

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Please Check All That Matter To You:

- ❑ Complete and comprehensive exam showing every problem that exists
- ❑ One problematic area looked at and addressed
- ❑ Continual cleanings
- ❑ IV Sedation
- ❑ Porcelain veneers
- ❑ Wisdom teeth removal
- ❑ Stop pain in teeth or gums
- ❑ Invisalign/Orthodontic Treatment
- ❑ Dentures/partials
- ❑ Implants
- ❑ I want to improve my smile and teeth
- ❑ I like the way my smile looks

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RECEIVE APPOINTMENT REMINDERS VIA EMAIL AND TEXT!

PLEASE CHECK A SOURCE IN WHICH YOU WOULD LIKE TO RECEIVE APPOINTMENT REMINDERS

- ❑ Email
- ❑ Text Message
- ❑ Both Email and Text Message

Email Address: _____
(if applicable)

Cell Phone: _____
(if applicable) **MUST REPLY WITH "Y" WHEN PROMPTED ON THE FIRST TEXT!**

We use this information to provide you with excellent treatment. We may disclose Patient Health Information (PHI) to third parties that perform services for Tempe Dental Care in the administration of your benefits in accordance with HIPAA. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate that performs services for Tempe Dental Care in the administration of your benefits. Our affiliates do not sell, share or rent our users' personally identifiable information unless required by law, do not send and e-mail or other communications without user permission, and do not send spam.

Please sign below that you agree to allow us to use this information in providing your services.

Patient Name: _____

Signature X_____ **Date** _____

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signature X_____ **Date** _____

FINANCIAL POLICY

Payment is expected **at time of service**. We will accept cash, check, credit card and Care Credit. Checks are accepted with valid driver's license only. **There will be a $25.00 service charge for a returned check**. We do not accept temporary checks.

Past due accounts may be turned over to a collection agency. Any fees incurred due to this, will be added to the outstanding balance. This may include late fees, collection agency fees, court fees etc.

We accept insurance. We will file your claims at no charge. It is the patient's responsibility to provide us with current insurance information prior to date services are performed.

If any payment from an insurance company becomes 30 days past due, you will be immediately billed for the entire balance.

Verification of eligibility and benefits payable by your insurance does not constitute a guarantee of claim payment. Final determination of benefits payable will be made at the time a claim is submitted and processed.

Not all services are covered by insurance. In the event that your insurance carrier determines a service "not covered" you will be responsible for the complete charge. If your insurance provides coverage for alternate services or downgrades any service, you will be responsible for whatever portion is not covered due to the modification made by your insurance. We will file pre-treatment estimates **AT YOUR REQUEST ONLY**. Please be aware that some insurance companies may not honor a pre-treatment estimate or may alter it. In all cases, it may delay important dental care.

Insurance limitations and regulations vary with all insurance plans. We do not base your treatment plan on what your insurance plan covers or does not cover. It's ultimately your responsibility to be aware of your dental plan coverage, regulations and limitations to avoid confusion and any surprises.

Signature X_____ **Date** _____

APPOINTMENT POLICY

Due to the high number of patients requiring dental care, certain appointment times might not be readily available. Because of this**, we enforce a missed appointment policy to ensure that all patients receive care as soon as possible.**

Appointments that are 2 hours or longer may be subject to pre-payment to ensure your scheduled time.

Missed appointments and appointments cancelled without 24-hour notice are subject to a cancellation fee of $25.00. Appointments that are 2 hours long or more may be subject to fee of $50.00.

I do hereby consent and acknowledge my agreement to the terms set forth in the FINANCIAL POLICY & APPOINTMENT POLICY FORM and any subsequent changes. I understand that this consent shall remain in force from this time forward.

Signature X_____ **Date** _____