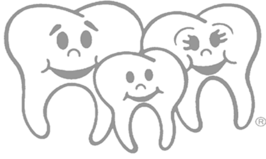


Tempe Dental Care

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 (_________)____________________

Preferred Pharmacy Name and Crossroads: ____

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: ______________________________ Insurance Phone #: ________________________

Insured's Name: ______________________________ Birth Date: ____________ ID#: ________________

Insured's Employer: ______________________________ Group #: ________________________

Relationship to Patient: ________________________ Is the insured person an existing patient? ❑ Yes ❑ No

Secondary Dental Carrier

Insurance Co Name: ______________________________ Insurance Phone #: ________________________

Insured's Name: ______________________________ Birth Date: ____________ ID#: ________________

Insured's Employer: ______________________________ Group #: ________________________

Relationship to Patient: ________________________ Is the insured person an existing patient? ❑ Yes ❑ No

The information on this page is correct to the best of my knowledge:

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
- ❑ Artificial Joint/Joint Replacement
- ❑ Asthma
- ❑ Blood Transfusion
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Colitis
- ❑ Congenital Heart Defect
- ❑ Diabetes
- ❑ Drug Abuse
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Excessive Bleeding
- ❑ Facial Surgery
- ❑ Fainting Spells
- ❑ Fever Blisters
- ❑ Frequent Headaches
- ❑ Glaucoma
- ❑ Head Injuries
- ❑ Heart Attack
- ❑ Heart Surgery
- ❑ Heart Murmur
- ❑ Hemophilia
- ❑ Hepatitis A,B,C
- ❑ High Blood Pressure
- ❑ HIV/Aids
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Mental Disorder
- ❑ Mitral Valve Prolapse
- ❑ Pace Maker
- ❑ Radiation Therapy
- ❑ Respiratory Problems
- ❑ Rheumatic Fever
- ❑ Seizures
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Problems
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Tumors
- ❑ Thyroid Problems
- ❑ Ulcers
- ❑ Venereal Disease

Allergies

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

Other Allergies:

____

Y N

❑ ❑ Do you Smoke or use Tobacco?

If Yes, how many per day? _________

Women Only

Y N

❑ ❑ Are you taking Birth Control?

❑ ❑ **Are you pregnant?**
If yes, # of weeks ___________

❑ ❑ Are you nursing?

Do you currently take blood thinners or daily aspirin per your medical doctor's recommendation? Y ( ) N ( )

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

Please list any other medications you are currently taking:

____

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____ ____________________

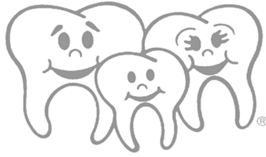
PATIENT OR PARENT/GUARDIAN SIGNATURE **DATE**

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

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

Date of Last Cleaning/Exam: ___________________________________



Tempe Dental Care

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

We invite you to participate in our online system: Features include:

- Appointment reminders
- Confirm appointments via Text or Email
- Request Appointments online
- **Receive notification of discounts and specials via Email!**

Cell # to opt in: ____

NOTE: You must reply with "Y" when you receive your welcome text!

Email to opt in: ____

Our affiliates do not sell, share or rent our users' personally identifiable information unless required by law, do not send e-mail or other communications without user permission, and do not send spam. 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.

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

Print Name: ____

Signature: ____ **Date:** _______________

FINANCIAL POLICY & APPOINTMENT POLICY

PLEASE READ THE ITEMS BELOW AND INITIAL:

__________ (initials) Payment is expected ***at time of service***. We accept cash, check, credit cards and financing through Care Credit. Checks are accepted with valid driver's license only. ***We do not accept checks over $500.00 and there will be a $25.00 service charge for a returned check***. We do not accept temporary checks.

__________ (initials) 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.

__________ (initials) 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.

__________ (initials) 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.

__________ (initials) 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.

__________ (initials) I understand that if I do not cancel within 24 hours of my scheduled evaluation or "no show" for any scheduled appointment I will be charged a $25.00 Cancellation/No Show Fee. 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**__________________

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 available by request.

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 have received and reviewed a copy of our dental practice’s privacy, security and breach notification policies and procedures.
I understand that I should ask our dental practice’s Privacy Official if I have any questions about these policies and procedures.

Print Name:____

Signature:____Date: ____________