Dental Design of Arcadia

New Patient Information

Patient Information:

Referred By: _____

First Name: _____

Last Name: _____

Preferred Name: _____

Email: _____

Address: _____

_____

Home Phone: _____

Cell Phone: _____

Date of Birth: _____

Gender: ____ Marital Status: _____

Social Security #: _____

Driver's License #: _____

Occupation: _____

Employer: _____

Work Address: _____

_____

Work Phone: _____

Billing Information:

*(Please complete in full if **different** than patient information)*

First Name: _____

Last Name: _____

Address: _____

_____

Home Phone: _____

Date of Birth: _____

Social Security #: _____

Occupation: _____

Employer: _____

Work Address: _____

_____

Work Phone: _____

In case of an emergency:

Please Contact: _____

Phone: _____

Relation to Patient: _____

CONFIRMATION PREFERENCE *(circle desired options)*: **TEXT** **EMAIL** **CALL** **CARD**

INSURANCE INFORMATION

Does the patient have dental insurance? _____ If yes, please present card at first visit.

Dental Design of Arcadia

Medical Update

If **female** please answer the following:

Y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant?
☐	☐	Are you nursing?

Please answer the following:

Y	N	
☐	☐	Do you smoke or use tobacco?

Height: Weight:

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Acid Reflux
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Joints
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer Chemotherapy
☐	☐	Radiation Therapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	COPD
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells

Y	N	Conditions
☐	☐	Fever Blisters
☐	☐	Frequent Headaches
☐	☐	Glaucoma
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	Hepatitis C
☐	☐	High Blood Pressure
☐	☐	High Cholesterol
☐	☐	HIV+ AIDS
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Pneumocystis
☐	☐	Psychiatric Problems
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Shingles

Y	N	Conditions
☐	☐	Sinus Problems
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

Medications:

Physician's Name: _____ Phone #: _____

Is there any disease, condition or problem that you think this office should know about that is not covered above? If yes, please describe below...

Signature: _____ **Date:** _____

(If under 18, Parent or Guardian Signature Required)

Patient Dental History

Patient Name: _____ Date of Birth: _____/_____/_____

REASON FOR YOUR VISIT: _____

LAST DENTAL VISIT? _____WHAT WAS DONE THEN? _____

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN? _____

PREVIOUS DENTIST (NAME AND LOCATION) _____

HOW OFTEN DO YOU BRUSH YOUR TEETH? _____ HOW OFTEN DO YOU FLOSS? _____

Do your gums bleed while brushing or flossing? YES NO

Are your teeth sensitive to hot or cold liquids/foods? YES NO

Are your teeth sensitive to sweet or sour liquids/foods? YES NO

Do any of your teeth feel painful? YES NO

Do you have any sores or lumps in or near your mouth? YES NO

Have you had any head, neck, or jaw injuries? YES NO

Have you experienced any of the following problems:

- Clicking in your jaw YES NO
- Pain (joint, ear, side of face) YES NO
- Difficulty in opening or closing your jaw YES NO
- Difficulty in chewing YES NO

Do you have frequent headaches? YES NO

Do you clench or grind your teeth? YES NO

Do you bite your lips or cheeks frequently? YES NO

Have you noticed any loosening of your teeth? YES NO

Does food tend to become caught between your teeth? YES NO

Have you ever had periodontal(gum) treatment? YES NO

Have you ever worn a night guard or other appliance? YES NO

Have you had any difficult extractions in the past? YES NO

Have you had prolonged bleeding after extractions? YES NO

Do you wear dentures or partials? YES NO If so, give the date they were placed:_____

If you could change anything about your smile, what would you change?

_____

_____

Financial Policy

We appreciate your selection of this office to serve your dental needs. Our interest is to provide our patients with the finest possible, quality dental care. We must attend to the financial aspects of dental treatment as well. The following is an overview of our office's financial policy.

Payment: Payment in full is required at the time of service. For your convenience, we accept cash, debit, and credit cards, including Visa, MasterCard, Discover, and American Express. Our office also offers Extended Payment Plans, upon approved credit, through CareCredit.

Insurance: Dental Insurance usually never pays for 100% of all dental services. As a courtesy, we will bill your dental insurance for your care, providing you give us the needed information for claim submission.

- At the time of your service, we will request from you an initial payment, the estimated portion of the charges which insurance may not cover, including all applicable deductibles and co-pays.
- After your dental insurance settles your claim, any remaining balance is your responsibility.
- Payment from the insurance company is expected within thirty (30) days. If your insurance company has not responded within a sixty (60) day grace period from the date of service, the remaining balance in full is your responsibility.
- Questions and concerns with your dental coverage and the payment of your claim(s) are the sole responsibility of the insured, and should be resolved with the insured's employer and/or dental insurance company. Your coverage is a result of the contract between the insured's employer and the dental insurance company. Our office has no control over payment or non-payment of your claims.
- As your dental care provider, we advise treatment that is in the best interest of your medical and dental health. Insurance companies select the dental procedures that they will and will not cover without regard to your personal situation, health, and dental needs.
- It is the sole responsibility of the patient, you, to familiarize yourself with the rules, terms, exclusions, clauses, and benefit limitations of your dental insurance policy.

Estimates: Before treatment, we will perform a diagnosis and provide you with an estimate of the charges involved. As a treatment progresses, it is possible that additional circumstances, not apparent at the initial exam, may be encountered. In the event that this happens, we will discuss options with you and proceed upon your arrival.

Aged Account: The total balance on your account, after claim settlement, is due immediately upon receipt of statement. Failure to keep this account current may result in Dental Design of Arcadia being unable to provide additional dental services. In the event of a default, I agree that any information collected can be used to collect on my account. I agree to pay all costs incurred in the attempt to collect on this account, including late fees, finance charges, collection agency fees, attorney's fees and court costs.

Copyright: Any comment posted online in any way relating to Dental Design of Arcadia or any employee, will be the sole right and property of Dental Design of Arcadia. The copyright of the content of the comment, rating, or review is hereby assigned to Dental Design of Arcadia to utilize or delete at our discretion in order to protect the patient and employee with anonymity and privacy.

Appointments: If unable to keep a scheduled appointment, we ask that you provide us with a 48 hour notice as a courtesy. **Notice of less than 48 hours will result in a minimum charge of $50.00, the amount will vary depending on the magnitude of the failed appointment.**

Assignment of Benefits: I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my dental claims. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Dental Design of Arcadia.

I have read and understood the financial policy, and I agree to the Dental Design of Arcadia financial policy.

_____	_____	_____
Signature of Person Responsible for Account	Printed Name of Person Responsible for Account	Date

DENTAL DESIGN OF ARCADIA

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 03/29/05, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.___ for each page, $___ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other

activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Alexis Mumphrey
Telephone: 480-994-5557
E-mail: reception@dentaldesignofarcadia.com
Address: 3409 N. 56th Street, Suite A. Phoenix, AZ 85018

Dental Design of Arcadia

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of
Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

_____

_____

_____

Release of Records

Date_____

Please accept this written request to release my dental records to:

Dr. Louis Maro, Dental Design of Arcadia

Dentist Name

3409 N. 56th Street, Ste A (480) 994-5557

Street Address Office Phone

Phoenix, AZ 85018

City, State Zip Code

Please email records to: maroandteam@gmail.com

Patient Information:

_____

Patient Name

_____

Street Address

_____

City, State Zip Code

_____

Patient Signature Date