Dysart Dental
Drs. Sam & Tracy Thomas, DDS
5220 N. Dysart Rd., #160
Litchfield Park, AZ
Tel: (623) 935-0500

Thank You for Selecting Our Dental Team
To help us meet all your healthcare needs, please fill out this form completely.
If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential) **Best Contact Phone Number** _____

Name_____Date_____

Gender: Male / Female (Please Circle) Email Address _____

Soc. Sec. #_____ Birth Date_____

Home/Cell Phone _____/_____

Address_____ City_____

State_____ Zip_____

Check Appropriate Box ☐Minor ☐Single ☐Married
☐Divorced ☐Widowed ☐Separated

If Student, Name of School/College_____ City_____ State _____
☐Full Time ☐Part Time

Patient's or Parent's Employeer_____
Work Phone_____

Business Address_____ City_____
State_____ Zip_____

Spouse or Parent's Name_____ Employer_____ Work Phone_____

Business Address_____ City_____
State_____ Zip_____

Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency_____

Responsible Party
Name of Person Responsible for this Account_____
Relationship to Patient_____
Addresss_____Home Phone _____
Employer_____ Work Phone _____SS#_____
Is this Person Currently a Patient in our Office? ☐Yes ☐No

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Insurance Information

Name of Insured_____
Relationship to Patient_____

Birth date_____ Social Security #_____
Date Employed_____

Employer Address_____City_____
State_____ Zip_____

Insurance Company_____ Group #_____
Policy/ID#_____

Ins. Co. Address_____ City_____ State____ Zip_____

How Much is Your Deductible? _____ How Much Have You Used? _____
Max. Annual Benefit_____

Do You Have Any Additional Insurance? □Yes □No If Yes, Complete the Following

Name of Insured_____
Relationship to Patient_____

Birth date_____ Social Security #_____
Date Employed_____

Employer Address_____City_____
State_____ Zip_____

Insurance Company_____ Group #_____
Policy/ID#_____

Ins. Co. Address_____ City_____ State____ Zip_____

How Much is Your Deductible? _____ How Much Have You Used? _____
Max. Annual Benefit_____

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Patient Medical History

Physician_____ Office Phone_____ Date of Last Exam_____

1. Are you under medical treatment now? □Yes □No

2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? □Yes □No
If yes please
explain._____

3. Are you taking any medications including non-prescription medicine? □Yes □No
If yes, what medication(s) are you taking?
_____

4. Have you ever taken Phen/Fen/Redux? □Yes □No 5. Have you ever taken Fosamax, Boniva, or Bisphosphonates? □Yes □No

6. Do you use tobacco? □Yes □No 7. Do you use controlled substances? □Yes □No

8. Do you have or have you had any of the following?

High Blood Pressure	□Yes	□No	Heart Disease	□Yes	□No	Chest Pains	□Yes	□No
Heart Attack	□Yes	□No	Cardiac Pacemaker	□Yes	□No	Easily Winded	□Yes	□No
Rheumatic Fever	□Yes	□No	Heart Murmur	□Yes	□No	Stroke	□Yes	□No
Swollen Ankles	□Yes	□No	Angina	□Yes	□No	Hay Fever/Allergies	□Yes	□No
Fainting/Seizures	□Yes	□No	Frequently Tired	□Yes	□No	Tuberculosis	□Yes	□No
Asthma	□Yes	□No	Anemia	□Yes	□No	Radiation Therapy	□Yes	□No
Low Blood Pressure	□Yes	□No	Emphysema	□Yes	□No	Glaucoma	□Yes	□No
Epilepsy/Convulsions	□Yes	□No	Cancer	□Yes	□No	Recent Weight Loss	□Yes	□No
Leukemia	□Yes	□No	Arthritis	□Yes	□No	Liver Disease	□Yes	□No
Diabetes	□Yes	□No	Joint Replacement or Implant	□Yes	□No	Heart Trouble	□Yes	□No
Kidney Diseases	□Yes	□No	Hepatitis/Jaundice	□Yes	□No	Respiratory Problems	□Yes	□No
AIDS/ HIV Infection	□Yes	□No	Sexually Transmitted Disease	□Yes	□No	Mitral Valve Prolapse	□Yes	□No
Thyroid Problem	□Yes	□No	Stomach Troubles/Ulcers	□Yes	□No	Other_____	□Yes	□No

9. Are you allergic to or have you had reactions to the following?

Local Anesthetics (e.g. Lidocaine,)	□Yes	□No	Penicillin or other Antibiotics	□Yes	□No
Sulfa Drugs	□Yes	□No	Barbiturates	□Yes	□No
Sedatives	□Yes	□No	Iodine	□Yes	□No
Aspirin	□Yes	□No	Any metals (e.g. nickel, mercury, etc.)	□Yes	□No
Latex Rubber	□Yes	□No	Other_____	□Yes	□No

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10. Women Only:

a. Are you pregnant or think you may be pregnant? □Yes □No

b. Are you nursing? □Yes □No

c. Are you taking oral contraceptives? □Yes □No

Patient Dental History

Name of Previous Dentist _____ Date of Last Exam_____

Previous Dentist's Location _____ Date of Last Cleaning_____

1. Do your gums bleed while brushing or flossing? □Yes □No

2. Are your teeth sensitive to hot or cold liquids/foods? □Yes □No

3. Are your teeth sensitive to sweet or sour liquids/foods? □Yes □No

4. Do you feel pain to any of your teeth? □Yes □No

5. Do you have any sores or lumps in or near your mouth? □Yes □No

6. Have you had any head, neck or jaw injuries? □Yes □No

7. Have you ever experienced any of the following problems in your jaw?

Clicking	□Yes	□No	Pain (joint, ear, side of face)	□Yes	□No
Difficulty in opening or closing	□Yes	□No	Difficulty in chewing	□Yes	□No

8. Do you clench or grind your teeth? □Yes □No

9. Have you ever had any difficulty extractions in the past? □Yes □No

10. Have you ever had any prolonged bleeding following extractions? □Yes □No

11. Have you had any orthodontic treatment? □Yes □No

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 diagnosis and the records of any treatment or examination rendered to me and/or my child during the period of such Dental care to third party and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____Signature of patient (or parent if minor)

Doctor's Comment_____

_____

Signature _____ Date _____

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Dysart Dental Financial Policy

Welcome to out dental office. It is our primary goal and responsibility to help our patients obtain good dental health. We have prepared this letter so that you may be aware of our financial policy.

Payment in full is expected at the time of treatment. Patients with dental insurance must provide accurate and complete insurance information. We will be happy to file for your insurance benefits as a courtesy to you, but we are not obligated to do so. Our relationship is with you and not your dental insurance company. The percentage covered for each procedure is determined by how much your employer has paid for coverage.

Our office does not determine your dental benefits. Some insurance carriers will not reimburse our office. In such instances, you will be responsible for the full cost of each visit at the time services are provided, and your insurance company will send you the reimbursement check directly.

We provide our patients with the finest treatment available and base our treatment recommendations on what will be best for you rather that what your insurance company does or doesn't pay. Our primary goal is to provide you with the best possible treatment. Unfortunately, the goal of many insurance companies is only to treat in the cheapest manner, not necessarily the safest or most effective.

At the initial appointment, you will be responsible for your portion of the fees not covered by your insurance company for that appointment, and payment is expected. Prior to completing any restorative treatment, however, we will provide you with a cost estimate of our total fee, your estimated insurance coverage, and your estimated out-of-pocket costs. Please remember, **these are only estimates and may change during the course of treatment.** Sometimes, treatment alternatives become necessary for various reasons, which may increase or decrease treatment costs. Further, most insurances do not tell us exactly what they will pay, so we are only giving you our best guess.

Any amount not covered by your insurance company is payable at the time service are rendered. These fees may include deductibles, co-payments or certain procedures not covered by your insurance policy. If your insurance does not pay within 45 days of the treatment rendered, we shall expect payment in full from you. After 90 days from the time of service and attempts to collect outstanding funds, patients/parents/guardians not fulfilling their financial obligation will be sent to collections.

If you have any questions, we will be happy to assist you. We look forward to beginning a wonderful relationship with you!

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Financial Policy (continued)

Our mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

-Cash, Check, Visa, MasterCard, American Express or Discover Card.

We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash, check or credit card **prior to completion of care for treatment plans of $500 or more.**

-NO INTEREST Payment Plans from Care Credit and Citi Health Card *[1]

- 6 Months Deferred Interest for charges $300 and above.
- 12 Months Deferred Interest for charges $1000 and above.
- 24, 36, 48 Months with Low Fixed Interest for charges $1000 and above.

Please note:

Dysart Dental requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For plans requiring multiple appointments, alternative payment arrangements may be available.

For patients with dental insurance we are happy to work with your carrier to maximize your benefits and bill them directly for reimbursement of treatment cost. *[2]

A fee of $25 is charged for patients who miss or cancel appointments without 24-hour notice.

Dysart Dental charges $25 for returned checks.

Service Charge- Unspecified collection fees may apply on past due accounts if not paid within 90days, after monthly billing period. I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts. I have read and understand that I am financially responsible.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need

_____

Patient, Parent or Legal Guardian Signature Date

Print Name Patient Name (Please Print)

*[1] Subject to credit approval.
*[2] However, if we do not receive payment from your insurance carrier within 90days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier. Proper notice will be provided to you if we are having difficulty obtaining reimbursement

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Notice of Privacy Practices at Dysart Dental

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

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 April 14, 2003, 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. In the event we make a material change in our privacy practices, we will change this Notice and provide it to you at your next visit or it can be viewed in the store or on our Web site.

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 health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care and service that you receive. Your health information is contained in a dental record that is the physical property of Dysart Dental.

How We May Use or Disclose Your Health Information

For Treatment

We may use or disclose your health
information to a dentist, specialist or other healthcare providers providing
treatment to you for:

-the provision, coordination, or management of health care and related services by health care providers;
-consultation between health care providers relating to a patient/customer;
-the referral of a patient for health care from one health care provider to another; or appointment reminders and recall information.

For Payment

We may use and disclose your health information to others for purposes of
processing and receiving payment for treatment and services provided to you.
This may include:

-billing and collection activities and related data processing;
-actions by a health plan or insurer to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims;
-medical necessity and appropriateness of care reviews, utilization review activities; and
-disclosure to consumer reporting agencies of information relating to collection of payments.

For Health Care Operations

We may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of staff to:

-evaluate the performance of our dentists;
-assess the quality of service, product and care in your case and similar cases;
-learn how to improve our facilities and services;
-conduct training programs or credentialing activities; and
-determine how to continually improve the quality and effectiveness of the products, service and care we provide.

Appointments, Treatment and Quality Assurance

We may use your information to provide appointment reminders or recall notices (such as voicemail messages, postcards or letters) or information about treatment alternatives or other health-related benefits, products and services that may be of interest to you. We may also contact you to conduct our own surveys about the quality of the products and services we provide.

To You, Your Family and Friends

We must disclose your health information to you, as described in the Your Health Information 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 or, if you are not able to agree, if it is necessary in our professional judgment.

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 or your general condition. 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, photos, or other similar forms of health information.

Required by law

We may use and disclose information about you as required by law. For example, we may disclose information for the following purposes:

-for judicial and administrative proceedings pursuant to legal authority;
-to report information related to victims of abuse, neglect or domestic violence;
-to assist law enforcement officials in their law enforcement duties; or
-to assist public health officials avert a serious threat to the health or safety of you or any other person.

Decedents

Health Information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

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Organ/Tissue Donation
Your health information may be used or disclosed for cadaver organ, or tissue donation purposes.

Research
We may use your health information for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research.

Government Functions
Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of your health information.

Workers Compensation
Your health information may be used or disclosed in order to comply with laws and regulations related to Workers Compensation.

Marketing Health Products or Services
We will not use your health information for marketing communications without your prior written authorization. We may provide you with information regarding products or services that we offer related to your health care needs. We will never sell your health information without your prior authorization.

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.

Your Health Information Rights

Access
You have the right to review 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 may be asked to 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 setting forth the specific information to which you desire access. If you request an alternative format, provided that it is practicable for us to produce the information in such 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, where you have provided an authorization and certain other activities, for the last 6 years, but not for disclosures made prior to 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 in writing that we communicate with you about your health information by alternative means or to alternative locations. 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. You may obtain a form to request an amendment to your health information by using the contact information listed at the end of this Notice.

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 Information
If you have any questions or complaints please contact:
HR Director
Dysart Dental
5220 N. Dysart Rd., #160
Litchfield Park, AZ 85340
Phone: 623-935-0500
Email: DysartDental@hotmail.com
Thank you for entrusting Dysart Dental with your dental care.

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PRIVACY POLICY ACKNOWLEDGEMENT STATEMENT

I have been told that Dysart Dental has a Privacy Policy in place according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

As a patient of Dysart Dental, I understand and acknowledge the following:

♦ Dysart Dental has a privacy policy in effect in their office.

♦ Dysart Dental has made this policy available to me and has made me aware, that as a patient. I am entitled to a copy of this privacy policy if I desire a copy for my personal files.

After reading these statements please sign at the bottom acknowledging that you have been advised of the privacy policy implemented by Dysart Dental, and have read and understand the acknowledgement form. If you would like a copy of the privacy policy, please ask for one at our front desk.

Patient or Legal Guardian Name Date