

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 Employer _____

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 _____

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

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

- | | |
|--|--|
| Local Anesthetics (e.g. Lidocaine,) <input type="checkbox"/> Yes <input type="checkbox"/> No | Penicillin or other Antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sulfã Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No | Barbiturates <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sedatives <input type="checkbox"/> Yes <input type="checkbox"/> No | Iodine <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No | Any metals (e.g. nickel, mercury, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Latex Rubber <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____ <input type="checkbox"/> Yes <input type="checkbox"/> 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 our 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 than 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 is 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.

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.

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.

A fee of \$50 is charged for patients who miss or cancel appointments without 24-hour notice.

Dysart Dental charges \$50 for returned checks.

Service Charge- Unspecified collection fees may apply on past due accounts if not paid within 90 days, 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)

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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