Valley of the Sun Dentistry

Patient Information

Last Name	First Name	Middle Name	Birthdate	Age

Address	City	Zip

Email Address	Home Phone	Cell Phone

Marital Status	Patient's Social Security Number	Occupation

Employment Address

Employer's Name	Work Phone Number

Preferred Way to contact for appointments, reminders, statements, announcements	How did you hear about our office?

Billing Information

Who is financially responsible?	Relationship to the patient

Home Phone	Cell Phone	Work Phone

Birthdate	Social Security Number	Employer

Employment Address	Insurance Company

Emergency Information

Spouse's Name	Address

Home Phone	Cell Phone	Work Phone

Person to contact in case of Emergency	Phone

Address

Nearest Relative not living with you	Phone

Address	

I consent to the treatment of the above named patient. I agree to give **24 hours** notice if an appointment can not be kept. I understand that there is a fee for not giving **24 hours notice.**

Signature	Date

Valley of the Sun Dentistry

Medical History

Physician	Address	Phone
Pharmacy	**Address**	**Phone**

CIRCLE EITHER Y FOR YES, OR N FOR NO FOR ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD.

Y	N	Recent illness or surgery				Y	N	HIV			
Y	N	Hospitalized in past 2 years				Y	N	Asthma			
Y	N	Heart or circulation trouble				Y	N	Sinusitis			
		Y	N	Heart Attack		Y	N	Shortness of breath			
		Y	N	Heart murmur		Y	N	Arthritis			
		Y	N	Mitral valve prolapse		Y	N	Artificial knee, hip or other joint			
		Y	N	Artificial heart valve or stent		Y	N	History of trauma to the jaw			
Y	N	High blood pressure				Y	N	Tuberculosis			
Y	N	Low blood pressure				Y	N	Thyroid trouble			
Y	N	Stroke				Y	N	Rheumatic fever			
Y	N	Anemia				Y	N	Glaucoma			
Y	N	Bleeding disorder				Y	N	Use tobacco			
Y	N	Blood transfusion						Y	N	Smoke	How much?
Y	N	Cancer or tumors						Y	N	Chew	How much?
Y	N	Radiation treatment				Y	N	Taking prescription drugs currently			
Y	N	Hepatitis, jaundice, or liver problems						Y	N	Hormone supplements, birth control	
Y	N	Kidney or bladder problems						Y	N	Antireaction drugs	
Y	N	Dialysis						Y	N	Anticoagulants, Coumadin	
Y	N	Diabetes						Y	N	Tranquilizers, sedatives	
Y	N	Family history of diabetes						Y	N	Pain relievers	
Y	N	Epilepsy				Y	N	Allergy or other reaction to any drug			
Y	N	Fainting				Drug				Reaction	
Y	N	Pregnant (due date)				Y	N	Other health conditions			

Dental History

What is your main reason for today's appointment			
When was your last full mouth X-ray?	**Where was it taken?**		
When was your last cleaning?	**Have you had treatment for gum disease?**	**Yes/No**	**When?**

CHECK ANY THAT PERTAIN TO YOU

	Dental Pain		Bleeding in mouth		Swelling
	Jaw clicks or pops when opening		Gums bleed		Frequent headaches
	Teeth sensitive to hot, cold or sweets		Have had root canal therapy		Grind teeth
	Have had orthodontic braces		Have had wisdom teeth removed		Tender to floss
	Desire to keep teeth if possible		Dissatisfied with how teeth look or feel		

Is there anything else that we should be aware of?	
Signature	**Date**

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Our Financial Policy

Thank you for choosing us as your dental care provider. The following is a statement of our financial policy which we require you to read and sign prior to any treatment. All patients must complete our information and insurance form before seeing the doctor. Please initial each line, and sign and date at the bottom.

_____ ***FULL PAYMENT IS DUE AT THE TIME OF SERVICE.***
WE ACCEPT CASH, CHECKS AND CREDIT CARDS.
WE CONTRACT WITH A LENDER FOR ANY EXTENDED PAYMENT PLAN WITH APPROVED CREDIT.

_____ ***Regarding Insurance:***

We accept assignment of insurance benefits, meaning your insurance can pay us rather than you pay us and then get reimbursed from your insurance company. Insurance plans do not cover some treatments, nor do they 100% of some covered treatments, and they require you to pay your deductible and co-insurance at the time of service. They do not have to pay your claim unless you meet this deductible and co-insurance. Your insurance policy is a contract between you and your insurance but the ultimate responsibility lies with you. If your insurance claim goes unpaid for 60 days, the balance will be due from you. We are able to keep a credit card on file and any unpaid balance can be transferred to your credit card to avoid any additional billing fees or finance charges. Please be aware that some and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under your dental insurance policy.

_____ ***Usual and Customary Rates (UCR)***

We charge fees that are considered usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

_____ ***Minor Patients***

The adult accompanying a minor and the parents (or guardians) of the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless payment will be made with cash, check, or credit card at the time of service.

_____ ***Missed Appointments***

Unless cancelled at least **24 hours in advance,** our policy is to charge for missed appointments. Please help us serve you better by keeping your scheduled appointments.

Thank you for understanding our financial policy. Please let us know if you have questions or concerns.

I have read the financial policy. I understand the financial policy.

X_____ Date_____
Signature of Patient or Responsible Party

X_____ Date_____
Signature of Co-Responsible Party

Valley of the Sun Dentistry

NOTICE OF PRIVACY PRACTICES

We are required by law to inform patients of our privacy policies and your rights concerning your health information. We reserve the right to change our privacy practices and the 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.

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. Referrals to specialist or dental labs include your name and information that is pertinent to the case.

Payment: We may use and disclose your health information to obtain payment for services we provide you including claims to dental insurance companies.

To Your Family and Friends: 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 health care, 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 judgement 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.

Non staff individuals: Due to the size and layout of our office, there will be times when individuals other than our staff may see you present here, or see your name and treatment planned on a schedule or chart. They also may overhear conversation regarding your condition or treatment, or the fees involved.

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, letters, emails or text messages).

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. There will be a charge for copying records. We are legally required to keep original charting as legal records. You must make a request in writing for copies five working days before they are wanted.

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 six years. 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 aby 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 payment 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.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have question 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 f 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: Jenn Herzhaft Telephone: 602-942-4260 Address: 18205 N. 51st Ave #155 Glendale, AZ 85308
I have been advised of these policies and agree to them.

Name_____ Date_____