Patient Information

Name: ______________________ Preferred Name: ______________________

Home Address: ______________________ City: ____________ State ______ Zip: ________

Home #: ______________ Work #: ______________ Mobile #: ______________

Email: ____

Sex: M / F Birth Date: ___/___/_____ SS#: ____________________

Family Status (circle): Single Married Divorced Child Spouse's Name: ______________

How did you first hear about our office? (circle one):

Another Patient	Another Dental Office	Brochure	Online Search
Facebook	Work	School	Insurance Website
Sign –Drive by	Walk in	Other: __________	

Whom may we thank for referring you to our practice? ______________________

Person Responsible for Account

Name of responsible party: ______________________________

Relationship to patient (Circle): Self Spouse Parent Other: ______________________

Home Address: ______________________ City: ____________ State: ________ Zip: ________

Home #: ______________ Work #: ______________ Mobile #: ______________

Email: ____

Birth Date: ___/___/_____ SS#: ____________________

Contact Information

What is the best way to communicate with you? Home Phone / Mobile Phone/ Text / Email

In the event of an emergency, whom should we contact? Name ______________________

Relationship __________ Home #: __________ Work #: __________ Mobile #: __________

Insurance Information (Primary)

Name of Insured: ______________________________ Relationship to patient: ______________________

Insured Birth Date: ___/___/_____

Insurance Plan Name: __________________________ Insurance Co Phone #: ______________________

Claims Address ____

City, State, Zip ____

Group #: _______________________________ ID #: _______________________________________

Insurance Information (Secondary)

Name of Insured: ______________________________ Relationship to patient: ______________________

Insured Birth Date: ___/___/_____

Insurance Plan Name: __________________________ Insurance Co Phone #: ______________________

Claims Address ____

City, State, Zip ____

Group #: _______________________________ ID #: _______________________________________

Cancellations, Late, and Missed Appointments

We require 48 hours advance notice of a cancellation. Patients who do not provide 48-hour notice of a cancellation or who do not present for a scheduled appointment may be charged a fee. Patients who fail to present for a second appointment may be charged a fee or dismissed from the practice. After the first missed appointment, a letter will be mailed reiterating our policy and reminding the patient of the risk of dismissal should another appointment be missed. We also have a 15-minute late policy.

I have read the Cancellation, late, and Missed Appointment Policy. I understand and agree to this Policy.

Patient Signature____Date____________

Medical History

Patient Name: ______________________________________ Date of Birth: ______________

1. Date of last physical exam: ________________ Physician's Name: ______________________________

2. Have you ever been hospitalized (if yes, explain below)? Yes No

____

3. Have you been under the care of a medical doctor during the past two years? Yes No
   If yes, what for? ____
4. Have you ever had any excessive bleeding requiring special treatment? Yes No
5. Women: Are you pregnant/trying to get pregnant/breast feeding? Yes No

6. Are you allergic to or have you had an allergic reaction to any of the following (please circle if yes):

Local Anesthetic	Penicillin	Codeine	Other Antibiotic: ____________
Latex	Acrylic	Metals	Other: ____________

7. Are you taking or have you ever taken any of the following medications (please circle if yes):

Fosamax	Actonel	Boniva	For how long? ____________
Aredia	Reclast	Zometa	When did you stop? ____________

8. Please list other medications you are taking:

____

____

Have you ever had any of the following?

Chest Pains	Yes No	Shortness of Breath	Yes No	Hives/Skin Rashes	Yes No
Heart Failure	Yes No	Ulcers	Yes No	Alcoholism	Yes No
Heart Disease	Yes No	Mental Health Issues	Yes No	Herpes	Yes No
Heart Attack	Yes No	Emphysema	Yes No	Glaucoma	Yes No
Heart Problems	Yes No	Fainting/Dizziness	Yes No	Steroid Treatment	Yes No
Angina Pectoris	Yes No	Eating Disorder	Yes No	Arthritis	Yes No
Heart Surgery	Yes No	Epilepsy/Seizures	Yes No	Dental Implant	Yes No
Liver Disease	Yes No	Persistent Cough	Yes No	Dentures/Partials	Yes No
Hypertension	Yes No	Tuberculosis	Yes No	Birth Defects	Yes No
Heart Murmur	Yes No	Asthma	Yes No	HIV+, AIDS, ARC	Yes No
Rheumatic Fever	Yes No	Hepatitis A	Yes No	Hay Fever	Yes No
Psychiatric Treatment	Yes No	Hepatitis B	Yes No	Tobacco Products	Yes No

Sickle Cell Disease	Yes No	Hepatits C or D	Yes No	Bruise Easily	Yes No
Sinus Trouble	Yes No	Pacemaker	Yes No	Jaundice	Yes No
Artificial Joints	Yes No	Night Sweats	Yes No	Kidney Trouble	Yes No
Thyroid Disease	Yes No	Stroke	Yes No	Diabetes	Yes No
Anemia	Yes No	Drug Addiction	Yes No	Chemotherapy	Yes No
Blood Transfusion	Yes No	Cold Sores	Yes No	Cancer	Yes No
Mitral Valve Prolapse (MVP)	Yes No	Radiation Therapy	Yes No	Transplant	Yes No

Dental History

1. Date of last dental exam:______________ Date of last dental x-rays: ______________________________
2. Previous dentist's name / location:____
3. Are you having tooth or gum pain at this time? Yes No
4. Do you feel nervous about having dental treatment? Yes No
5. Have you ever had a bad experience in a dental office? Yes No
6. Do your gums bleed when brushing / flossing? Yes No
7. Have you ever seen a periodontist? Yes No
8. Have you ever had a "deep cleaning" (Scaling and Root Planing)? Yes No
9. Is there anything you would like to speak with the Doctor about in private? Yes No
10. Would you be interested in discussing ways to improve your smile? Yes No

If yes, please explain: ____

Do you have any of the following dental concerns:

Clicking in jaw joint	Yes No	Sensitivity to:	Hot	Cold	Sweets	Biting
Pain in or around your ears	Yes No	Swelling		Bleeding Gums		
Difficulty opening or closing	Yes No	Bad Taste		Bad Breath		
Difficulty chewing	Yes No	Food Catching		Tooth Pain		
History of trauma to jaw or face	Yes No	Clenching		Grinding		
Diagnosis of TMJ/TMD	Yes No	Other: ______________				

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

Signature: ________________________________ Date______________________

Doctor's Signature____

Doctor's Notes:

Financial Guidelines

Payment for treatment is due and payable the day services are rendered. It is our goal, however, to assist all our patients in obtaining the dental treatment they deserve. Therefore, we are pleased to offer several payment options. Please read the following carefully. Our financial coordinator will answer any questions you may have and assist you in selecting the appropriate financial plan for your needs.

For your convenience, we offer the following financial options:

1. In addition to cash, we also accept payment through MasterCard/Visa, American Express, and Discover.

2. We offer extended payment plans with Care Credit

3. Dental Insurance

We are happy to file insurance claims and assist you in obtaining the maximum benefits specified in your contract. However, please keep the following in mind:

- Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract. We will do our best to ESTIMATE your coverage and file your insurance on your behalf. Not all dental services are necessarily covered under your dental insurance plan. It is essential that you read and understand your coverage and pay special attention to any preauthorization requirements, exclusions and waiting periods.

- Our office policy states that you are totally responsible for your bill. The ESTIMATED patient portion of the fee is due at the time of service. If a balance remains after we receive payment from your insurance carrier within 30 days, we will notify you. Failure of your insurance carrier to reimburse our office within 30 days will result in our billing you directly for the remaining balance.

- We are committed to providing the highest quality of care. Our treatment recommendations and the dental services we provide are in the best interest of the patient's health. The patient is responsible for payment in full regardless of an insurance company's arbitrary determination of treatment necessity.

- Our participation in a Preferred Provider Organization (PPO) is a contract between this office and the organization to provide dental services for the negotiated network fee schedule. Individual coverage and benefits will vary within the organization and are dependent on the contract between you, your employer, and the insurance company. While we guarantee our fees will not exceed the network fee schedule, we cannot be responsible for variances in coverage and benefits within the PPO.

- If your coverage changes for any reason, please notify the office immediately.

By signing this form, you have read and understand our policy. Any denials or insurance payments less than estimated will be your responsibility. Payment will be due upon our billing cycle. If for any reason your account goes to collections, the guarantor will be responsible for all fees. All estimated out of pocket fees and deductibles are due the day of treatment. Ask our office regarding our financial options before your visit, or if you have any questions regarding your insurance and our policy.

Usual and Customary Fees

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area and experience. You are responsible for payment regardless of any insurance company's arbitrary determination for usual and customary fees.

I have read the Financial Policy. I understand and agree to this Policy.

__________________________________ ____________

Signature of Patient or Responsible Party Date

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ______________________________

State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with a Notice of Privacy Practices. Our Notice is available online. If you prefer a paper copy, please ask a team member for a copy of our Notice.

I acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

____

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
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (Please Specify)

Authorization for Release of Information to Family and/or Friends

Name of Patient________________________Date of Birth_________

Queen Creek District Dental is authorized to discuss my dental care and may release my confidential health information to the following:

____________________________ ________________________

Name Relationship

____________________________ ________________________

Name Relationship

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to **Queen Creek District Dental.** I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed because of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in force and effective until revoked by the patient or representative signing the authorization.

____________________________________ Date_________________

Signature of Patient or Personal Representative

____

Description of Personal Representative's Authority (attach necessary documentation)

Patient Name: ____________________ or

Parent/Guardian name: ___________________________ **Temperature:** __________

Date: ______________

Answer the questions below by placing an "X" in the appropriate box.

Please tell us if you have any of the following:		YES	NO
1. Have you or a household member been previously tested for COVID-19?		Person: ________ Positive: _____ Negative: _____ Date: _________	
2. Symptoms consistent with COVID-19	a. Fever		
	b. Severe cough		
	c. Shortness of breath		
	d. Loss of taste/smell		
3. Have you or a household member been in close contact with a COVID-19 person?			
4. Have you or a household member traveled in the last 14 days?	a. Traveled outside the United States		
	b. Person traveled: __________ c. If YES, from __________ to __________		
	d. Traveled within the United States (distance of 100 miles or more)		
	e. Person traveled: __________ f. If YES, from __________ to __________		

COVID-19 Pandemic Dental Treatment Consent Form

I, ____________________________________, knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic.

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not, given the current limits in virus testing.

Dental procedures create water spray which is how the disease is spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

· I understand that due to the frequency of visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office. ________ (initial)

********CONTINUES ON THE BACK SIDE OF SHEET***********

· I confirm that I am not presenting any of the following symptoms of COVID-19 listed below:

· Fever

· Shortness of Breath

· Cough

· Runny Nose

· Sore Throat

___________ (initial)

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. And the CDC recommends social distancing of at least 6 feet for a period of 14 days to anyone who has, and this is not possible with dentistry. _______(initial)

· I verify that I have not traveled outside the United States in the past 14 days. _______ (initial)

Name: ____ Date: ____________________