

**102 Arizona Smile Design**

Arizona Smile Design  
 13576 W Camino Del Sol Ste 18  
 Sun City West, AZ 85375  
 Ph # : 623-474-3343



Patient Personal Information			
Title	Preferred Name	Birth Date	Age
Last, First		Marital Status	Sex
Address		Home #	Work #
		Cell #	Drive Lic
City, State, Zip		Emergency Contact	Emergency Phone #
Email		Student	SSN
Health Care Guardian Name		School Name	
Health Care Guardian Phone #		Referral Type	

Person responsible/guarantor for paying bills			
Title	Preferred Name	Birth Date	Age
Last, First		Marital Status	Sex
Address		Home #	Work #
		Cell #	Drive Lic
City, State, Zip		SSN	
Email			

Do you have Primary Dental Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have Secondary Dental Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Group No/Name		Group No/Name	
Insurance Name		Insurance Name	
Phone #		Phone #	
Employer Name		Employer Name	
Subscriber Last, First		Subscriber Last, First	
Subscriber Address		Subscriber Address	
City, State, Zip		City, State, Zip	
Relationship to Patient	Birth Date	Relationship to Patient	Birth Date
Subscriber ID		Subscriber ID	

Patient Medical Information			
<b>Existing Patients:</b>	<input type="checkbox"/> Y <input type="checkbox"/> N Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N Gag Reflex	<input type="checkbox"/> Y <input type="checkbox"/> N Sexually Transmitted Disease
<b>Allergic To</b>	<input type="checkbox"/> Y <input type="checkbox"/> N Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N Hay Fever	<input type="checkbox"/> Y <input type="checkbox"/> N Shortness of Breath
<input type="checkbox"/> Y <input type="checkbox"/> N Aspirin	<input type="checkbox"/> Y <input type="checkbox"/> N Autoimmune Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Heart Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Skin Rash
<input type="checkbox"/> Y <input type="checkbox"/> N Amoxicillin	<input type="checkbox"/> Y <input type="checkbox"/> N Blood Clotting Problems	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack	<input type="checkbox"/> Y <input type="checkbox"/> N Sinus Trouble
<input type="checkbox"/> Y <input type="checkbox"/> N Barbiturates / Sleeping Pills	<input type="checkbox"/> Y <input type="checkbox"/> N Bulimia	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Stomach Ulcers
<input type="checkbox"/> Y <input type="checkbox"/> N Codeine	<input type="checkbox"/> Y <input type="checkbox"/> N COPD	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur	<input type="checkbox"/> Y <input type="checkbox"/> N Stroke/TIA
<input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin	<input type="checkbox"/> Y <input type="checkbox"/> N Cancer / Tumor or Growth	<input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker	<input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Problems
<input type="checkbox"/> Y <input type="checkbox"/> N Iodine	<input type="checkbox"/> Y <input type="checkbox"/> N Cardiac Pacemaker	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis
<input type="checkbox"/> Y <input type="checkbox"/> N Latex Rubber	<input type="checkbox"/> Y <input type="checkbox"/> N Cardiovascular Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Herpes	<input type="checkbox"/> Y <input type="checkbox"/> N Unusual Weight Loss
<input type="checkbox"/> Y <input type="checkbox"/> N Local Anesthetics	<input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy/Radiation	<input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N Urinate Frequently
<input type="checkbox"/> Y <input type="checkbox"/> N Metals	<input type="checkbox"/> Y <input type="checkbox"/> N Chronic Pain	<input type="checkbox"/> Y <input type="checkbox"/> N Blood disease	<b>Other</b>
<input type="checkbox"/> Y <input type="checkbox"/> N No Epinephrine	<input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect	<input type="checkbox"/> Y <input type="checkbox"/> N Blood thinners	<input type="checkbox"/> Y <input type="checkbox"/> N AFib
<input type="checkbox"/> Y <input type="checkbox"/> N Penicillin	<input type="checkbox"/> Y <input type="checkbox"/> N Congestive Heart Failure	<input type="checkbox"/> Y <input type="checkbox"/> N Osteopenia/Osteoporosis	<input type="checkbox"/> Y <input type="checkbox"/> N High Cholesterol
<input type="checkbox"/> Y <input type="checkbox"/> N Sulfa Drugs	<input type="checkbox"/> Y <input type="checkbox"/> N Damaged Heart Valve	<input type="checkbox"/> Y <input type="checkbox"/> N Kidney disease	<input type="checkbox"/> Y <input type="checkbox"/> N Special Needs
<input type="checkbox"/> Y <input type="checkbox"/> N Other Allergies	<input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N Hives	<input type="checkbox"/> Y <input type="checkbox"/> N Autism Spectrum Disorder (ASD)
<input type="checkbox"/> Y <input type="checkbox"/> N No Known Allergies	<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N Jaundice	

<b>Check, if applicable</b>	<input type="checkbox"/> Y <input type="checkbox"/> N Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N Leukemia	<input type="checkbox"/> Y <input type="checkbox"/> N Parkinson's Disease
<input type="checkbox"/> Y <input type="checkbox"/> N Premedicate Prior To Dental Tx	<input type="checkbox"/> Y <input type="checkbox"/> N Environmental Allergies	<input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Sleep Apnea Appliance
<input type="checkbox"/> Y <input type="checkbox"/> N Joint Replacement	<input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure	
<input type="checkbox"/> Y <input type="checkbox"/> N Alcohol/Drug Abuse	<input type="checkbox"/> Y <input type="checkbox"/> N Fainting Spells	<input type="checkbox"/> Y <input type="checkbox"/> N Lupus	
<input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N Fever Blisters	<input type="checkbox"/> Y <input type="checkbox"/> N Mental Health Problems	
<input type="checkbox"/> Y <input type="checkbox"/> N Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N Frequent Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse	
<input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Infection	<input type="checkbox"/> Y <input type="checkbox"/> N Frequently Dry Mouth / Sjogren	<input type="checkbox"/> Y <input type="checkbox"/> N Seizures	

**Additional Comments**

---

**Dental Questionnaire**

**Dental Questionnaire**

If you are required to take a pre-medication prior to receiving dental treatment please list here. \_\_\_\_\_

Date of your last cleaning \_\_\_\_\_

Do you chew/smoke tobacco in any form ? \_\_\_\_\_

Are you having any specific problems with your teeth, gums, or mouth at this time ? \_\_\_\_\_

Do you use an electric toothbrush? \_\_\_\_\_

Do you use a WaterPik? \_\_\_\_\_

Do you wear a night guard at night? \_\_\_\_\_

**Additional Comments**

Any Disease, Condition or Problem not Listed ? Please list \_\_\_\_\_

**Medical Questionnaire**

**Emergency Contact**

Emergency contact name \_\_\_\_\_

Emergency contact phone \_\_\_\_\_

Emergency contact relationship to patient \_\_\_\_\_

City / State / Zip \_\_\_\_\_

**Medical Questionnaire**

Family Physician \_\_\_\_\_

Phone \_\_\_\_\_

Have you had any serious illness, operation or been hospitalized within the past 5 years ? \_\_\_\_\_

If Yes, what illness or problem ? \_\_\_\_\_

Are you currently taking any medication ? \_\_\_\_\_

If Yes, please list all medications-prescription and over-the-counter: \_\_\_\_\_

Have you taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast) \_\_\_\_\_

Have you ever taken the diet control drug Fen-Phen ? \_\_\_\_\_

On average, how many alcoholic beverages do you consume in a week ? \_\_\_\_\_

Do you smoke? \_\_\_\_\_

**Women Only**

Do you have menstrual period problems ? \_\_\_\_\_

Are you on hormone replacement therapy ? \_\_\_\_\_

Are you on birth control pills / fertility drugs ? \_\_\_\_\_

Are you pregnant? \_\_\_\_\_

If Yes, what is your due date ? \_\_\_\_\_

Are you currently nursing ? \_\_\_\_\_

**Additional Comments**

Please elaborate to any items marked "yes" ? \_\_\_\_\_

Any Disease, Condition or Problem not Listed ? Please list \_\_\_\_\_

**Additional**

Have you had joint replacement surgery? \_\_\_\_\_

Have you ever had a heart attack, stent placement, or a heart valve replaced? \_\_\_\_\_

Have you ever had a seizure or been diagnosed with a seizure disorder? \_\_\_\_\_

Are you taking blood thinners? \_\_\_\_\_

By signing below, I certify that all of the above information is true to the best of my knowledge.

\_\_\_\_\_  
**Patient/Guardian Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Dentist Signature**

\_\_\_\_\_  
**Date**

## Dental Practice Policies

Dear Patient:

Welcome to our dental office. We appreciate the opportunity to assist you with your dental care needs. Our goal is to provide you and your family with the best dental care available at an affordable cost and in an efficient and professional manner. We can only accomplish this goal with your help. With this in mind, we have listed our office policies below for your review.

\_\_\_\_\_ **Should you be unable to make your scheduled appointment we request that you notify the office at least 24 hours in advance.** We will make every effort to confirm your appointment with you; however, it is your responsibility to keep that appointment. A broken appointment fee of **\$45.00 Monday-Friday and \$75.00 for Saturday** may be billed to your account if you fail to notify the office within the time frame specified.

\_\_\_\_\_ Payment is due at the time of service. We accept cash, money orders, debit cards and all major credit cards as payment. For your convenience, we accept most dental insurances. As a courtesy, we will be happy to file your dental insurance claim to your insurance company on your behalf. **Insurance claims that are not paid within (60) days become the sole responsibility of the patient. If the balance on your account becomes more than (90) days past due, your account will be transferred to a collections agency and a fee of 30% of the balance will be added to your account.**

\_\_\_\_\_ We try very hard to adhere to a schedule. If you are more than 15 minutes late, we may have to reschedule your appointment. Sometimes an emergency will occur that will make us run behind. We do respect your time and will make every effort to stay as close to your appointment time as possible. We thank you for choosing our dental family and look forward to a long relationship with you.

\_\_\_\_\_ Please understand that dentistry is **not** an exact science and therefore reputable practitioners cannot properly guarantee results. No guarantee or assurance has been made by anyone regarding dental treatment that you have requested or authorized. Each dentist is an individual practitioner and is individually and solely responsible for the dental care rendered.

\_\_\_\_\_ Your original records belong to the office. You may request copies for you or others. We will provide them within five business days upon receiving a written request from you. There will be a fee to duplicate your chart.

\_\_\_\_\_ The patient and dentist (including their corporations, representatives, staff, agents, parents, guardians, children and all related individuals and entities) agree that all litigation events that occurred in the dental office will be determined through submission to an arbitrator, and NOT by a lawsuit or other legal proceeding filed in a federal, state, county or municipal court. By signing this Arbitration Agreement, the parties waive and forfeit their constitutional, statutory or common law rights for a jury or judge to decide any legal questions or disputes, and instead accept the sole use of a private arbitrator. This Arbitration Agreement covers all disputes as to dental treatment, financial matters or any other events that occurred in dental office whether in tort (intentional or negligent), contract, statute, common law or otherwise, and including without limitation all actions relating to dental negligence, return of fees, loss of consortium, wrongful death, discrimination, emotional distress or punitive damages. The arbitration shall bind all parties, including without limitation any spouse or heirs, and will NOT be subject to court review. Either party may initiate arbitration by serving on the other a written "Demand for Arbitration" form by certified mail. No other form of service will be acceptable. The Demand for Arbitration must identify all parties, include their contact information, describe the claims against each party, and state the amount of damages sought. Either party then may continue the proceedings by contacting the American Arbitration Association ("AAA"). A single AAA arbitrator, mutually selected by the parties, will conduct the arbitration. All proceedings will be resolved using the AAA rules. Arizona law will apply. If any provision of this Arbitration Agreement is held to be invalid or unenforceable, the remaining provisions will remain in full force and effect.

Patient Signature: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Patient Print Name: \_\_\_\_\_

Witness Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

## Notice of Privacy Practices

Federal & State laws require Arizona Smile Design to maintain the privacy of all patient healthcare information. Furthermore, we are required by law to provide all parents or legal guardians with this notice reviewing our privacy practices, our legal obligations, and your rights in regard to your child's healthcare information. Arizona Smile Design must follow the privacy practices as described within this notice while this policy is in effect. This notice takes effect on February 1<sup>st</sup>, 2008 and will remain in effect until replaced, amended, or eliminated.

Arizona Smile Design reserves the right to change these privacy practices and the terms of this notice at any time provided such applicable laws permit such changes. We reserve the right to make any needed changes to our privacy practices and these new terms will be effective for all health information that we maintain, including health information we create or receive before such made changes. Before we make any significant changes to our privacy practices, we will change this notice and make new notice available upon request.

Parent or legal guardians may request a copy of this notice, at any time. For additional information about our privacy practices or to review our company's Health Insurance Portability & Accountability Act (HIPAA) Manual, please contact our office at any time.

### **USES & DISCLOSURES OF HEALTHCARE INFORMATION**

Arizona Smile Design will use and disclose patient healthcare information during your treatment, while obtaining payment from insurance companies and during general healthcare operations. For example:

**Treatment.** Arizona Smile Design may use your health information during direct treatment or by disclosing such information to other dentists, physicians or healthcare providers who may provide specialized treatment for you.

**Payment.** We may also use and disclose your health information to obtain payment for services rendered. We may disclose your healthcare information to another healthcare provider or entity that is also subject to these same federal & state privacy rules and regulations for payment activities.

**Healthcare Operations.** We may use and disclose your healthcare information during our routine healthcare operations. Healthcare operations may include quality assessments and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluation practitioner and provider performance, conducting training programs, accreditation, and certification, licensing, or credentialing activities. We may disclose your healthcare information to another healthcare provider or organization that is subject to the same federal & state privacy rules and regulations and that has a relationship with you during the support of healthcare operations. We may disclose your information to help such organizations conduct quality assessment and improvement activities, review the competence or qualifications of healthcare professionals, or detect or prevent healthcare fraud or abuse.

**On Your Authorization.** You may give Arizona Smile Design written authorization to use your healthcare information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any issues or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your healthcare information for any reason except those described within this notice.

**To Your Family & 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 previously performed healthcare services. Before we disclose your health to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event you are incapacitated and cannot make a decision for yourself, or in the event of an emergency, we will disclose your medical information based on our professional judgment of practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical/dental supplies, radiographs or other similar forms including health information. We may also use or disclose information about you to notify or assist in notifying a person involved in his/her care.

**Appointment Reminders.** Arizona Smile Design may use or disclose your healthcare information to provide you and your family with appointment reminders. (Such as: telephone calls, voice messages, postcards, or letters)

**Disaster Relief.** We may use or disclose your healthcare information, as authorized by federal or state law for the following purposes deemed to be in the public's best interest or benefit:

- As required by law

- For public health activities, including disease and vital statistic reporting, reporting child abuse or neglect, FDA oversight and to employer's regarding work-related illness or injury.
- To health oversight agencies
- In response to court and administrative orders and lawful processes
- To law enforcement officials pursuant to subpoena and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies and for purposes of identifying or locating a suspect or other persons.
- To coroners, medical examiners and funeral directors
- To an organ procurement organization
- To avert serious threat to health or safety
- In connection with certain research activities
- To the military and to federal officials for lawful intelligence, counterintelligence and national security activities
- To correctional institutions regarding inmates
- As authorized by state worker's compensation laws

### **PATIENT or PARENT/LEGAL GUARDIAN RIGHTS**

**Access.** You have the right to look at or receive a copy of your health information, with limited expectations. You may request that we provide a copy in format other than photocopies. We will use the format you request unless we cannot practically do so. You must make all requests in writing to obtain access to your child's healthcare information. You may request access by sending us a letter. If you request a copy, we will charge you a reasonable fee, which may include labor, copying costs and postage. 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 may, but are not required to, prepare a summary or an explanation of your health information for a fee.

**Disclosure Accounting.** You have the right to receive a list of instances in which Arizona Smile Design or any business associates disclosed your health information over the past year (but not prior to June 24th 2010). That list will not include disclosures for treatment, payment, healthcare operations, as authorized by you and certain activities. 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 the use or disclosure of your healthcare information. We are not required to agree with such additional restrictions, but if we do, we will abide by our agreement (except in the event of an emergency). Any agreement we make to a request for additional restrictions must be in writing and signed by our privacy officer. Your request is not binding unless our agreement is in writing.

**Alternative Communication.** You have the right to request that we communicate with you about your health information by an alternative means or at an alternative location. You must make your request in writing. You must specify in your request the alternative means or location and satisfactory explanation how you will handle payment under the alternative means or location you request.

**Amendment.** You have the right to request that we amend your healthcare information. Your request must be in writing and should explain why you are requesting this amendment. We may deny your request under certain circumstances.

### **QUESTIONS OR COMPLAINTS**

If you need additional information regarding our office's Privacy Practices & Regulations or have specific questions or concerns, please feel free to contact us. Furthermore, if you believe that:

- We may have violated your privacy rights
- We made a decision about access to your health information incorrectly
- Our response to a previous request to amend or restrict the use or disclosure of your information was incorrect
- We should communicate with you by alternative means or an alternative location

You may submit a written complaint with our privacy officer or directly to the US Department of Health & Human Services. We will provide you with these addresses to file your complaint, upon request. We support your right to the privacy of your child's health information. We will not retaliate in any way if you choose to file a complaint with us or the US Department of Health & Human Services.

***I understand the contents of the previous notice concerning the privacy of my confidential healthcare information. I do hereby provide consent for the standard use of such information and understand that these provisions prohibit Arizona Smile Design from selling or transferring this information to any unauthorized locations without my prior approval. I have reviewed this information and all questions have been answered to my satisfaction.***

---

Signature of Patient/ Parent or Guardian

---

Date

**AUTHORIZATION TO RELEASE & DISCUSS DENTAL INFORMATION FORM**

The HIPPA privacy law requires that we are only authorized to communicate with patients themselves, insurance providers and primary care doctors, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. Spouses are not automatically included; their names must be explicitly stated below.

**Authorization to Speak with Family/Friend (including spouses)**

I give the following named person(s) authorization to take messages or speak with the office of Arizona Smile Design on my behalf regarding (please check all items authorized):

Name of Authorized person: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Appointments          Financial          Dental Treatment          Insurance          Other

Name of Authorized person: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Appointments          Financial          Dental Treatment          Insurance          Other

**I understand my express consent is required to release my health care information.** With my signature below, I acknowledge and understand that this information will be kept in my medical record, and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed below.

Print Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_