Island Dental

FAMILY AND COSMETIC DENTISTRY

About You

Todays Date:_____

Email Address:_____

Name:_____

I prefer to be called:_____ M_____ F_____

Birthdate:_____ Age:_____ SS#:_____ _____

Home Address:_____ Apt/Condo#:_____

City:_____ State:____ Zip:_____

___Single ___Married ___Divorced __Widowed __Separated

Home: (____)_____ Cell: (____)_____

Work: (____)_____ Ext:_____ DL#:_____

Employer:_____

Employer Address:_____

City:_____ State:____ Zip:_____

Whom may we thank for referring you?_____

Whom was your last Dentist?_____

When was your last dental visit?_____

Primary Dental Insurance

Insurance Company Name:_____

Insurance Company Address:_____

Insurance Company Phone:_____

ID#:_____ or Policy#:_____

Group #:_____

Insured's Name:_____ _____ Relation:_____

Insured's Birthday:_____ Insured's SS#:_____

Insured's Employer:_____

Secondary Insurance

Insurance Company Name:_____

Insurance Company Address:_____

Insurance Company Phone:_____

ID#:_____ or Policy#:_____ Group #:_____

Insured's Name:_____ _____ Relation:_____

Insured's Birthday:_____ Insured's SS#:_____

Insured's Employer:_____

Spouse Information

His / Her Name:_____

Employer:_____

Work: (____)_____ Ext:_____ SS#:_____

Birthdate:_____

Emergency Information

In the event of an emergency, is there someone who lives near you that we should contact:

His / Her Name:_____

Relation:_____

Work: (____)_____ Ext:_____ Home: ( )_____

Person Responsible for Account

Self: □

Name:_____

Work: (____)_____ Ext:_____ Home: ( )_____

Billing Address:_____

Relation:_____ SS#:_____

Employer:_____ DL#:_____

Medical History

Do you have a Physician: ____ Yes or ____ No

Physician's Name:_____

Office #: (____)_____ Date of last visit:_____

Are you currently under the care of a Physician? ____Yes ____No

Please explain:_____

_____

_____

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Medical History (continued)

Your current physical health is: ___Good ___Fair ___Bad

Are you taking any prescription, over the counter or supplement drugs? ___Yes ___No

Please list each one (or provide list of all medications)

_____

_____

_____

_____

Do you smoke or use tobacco in any other form ___Yes ___No

Have you ever taken Phen-Pen (Also known as Redux or Pondimin) ___Yes ___No

If so, when?_____

For Women: Are you taking birth control pills ___Yes ___No

Are you pregnant? ___Yes ___No Number of weeks:_____

Are you nursing? ___Yes ___No

Have you ever had any of the following diseases or medical problems? (please mark all answers)

Yes/No	Yes/No
__/__Alcohol/Drug Abuse	__/__ Heart Surgery/Pacemaker
__/__Allergies/Hay Fever	__/__ Hemophilia
__/__Anemia	__/__ Hepatitis A, B, C
__/__Arthritis	__/__ **High Blood Pressure**
__/__**Artificial Joints/Valves**	__/__ HIV+/Aids
__/__Asthma	__/__ Hospitalized
__/__Bisphosphonate_____	__/__ Jaundice
__/__**Blood Thinner_____**	__/__ Kidney problems
__/__Blood Transfusion	__/__ Liver Disease
__/__Cancer/Chemotherapy	__/__ **Low Blood Pressure**
__/__Congenital Heart Failure	__/__ Mental Disorders
__/__Diabetes	__/__ Mitral Valve Prolap
__/__Difficulty Breathing	__/__ Radiation Treatment
__/__Dizziness	__/__ Respiratory Problems
__/__Emphysema/Glaucoma	__/__ Stroke
__/__Epilepsy/Seizures/Fainting	__/__ Thyroid-Hype/Hypo
__/__Excessive Bleeding	__/__ Tuberculosis
__/__Fever Blisters/Herpes	__/__ Ulcers/Colitis
__/__Heart Attack/Stroke	__/__ Venereal Disease
__/__Heart Murmur	

Are you allergic to any of the following:

Yes/No	Yes/No	Yes/No
__/__Aspirin	__/__Erythromycin	__/__**Penicillin**
__/__Codeine	__/__Metals/Jewelry	__/__Sulfa
__/__Dental Anesthetics	__/__**Latex**	__/__Tetracycline
		__/__Other

Please list any other drugs/materials that you are allergic to:

_____

Dental History

Why have you come to the dentist today?

_____

_____

Do you require antibiotics before dental treatment recommended by your medical doctor? ___Yes ___No

Are you currently in pain? ___Yes ___No

Have you ever had a serious/Difficult problem associated with any previous dental work? ___Yes ___No

Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/Tmd)? ___Yes ___No

Do you like your smile? ___Yes ___No

Do your gums ever bleed? ___Yes ___No

How many times a day do you brush?_____

How many times a week do you floss?_____

Type of bristles? ___Hard ___Medium ___Soft

Your current dental health is? ___Good ___Fair ___Poor

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature Date

Financial Responsibility:

I further agree to pay all financial charges, collection cost, attorney fees, and any other cost that may be incurred to enforce collection of any amount outstanding.

_____

Signature Date

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Reviewing Doctor

_____

Signature Date

ISLAND DENTAL
FAMILY AND COSMETIC DENTISTRY

1489 W. Elliot Rd. Suite #101• Gilbert, AZ 85233

Phone 480-507-9400

www.gilbertarizonadental.com

NOTICE OF PRIVACY PRACTICES

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.

Island Dental is committed to protecting your privacy, and we have adopted privacy practices to protect the information we gather from you. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. The Notice of Privacy Practices ("Notice") describes the privacy practices of Island Dental and will tell you about the ways in which we may use and disclose medical information about you and how you can get access to this information. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information with respect to your "Protected Health Information" (as defined by the Health Insurance Portability and Accountability Act of 1996 and its regulations, as amended from time to time).

We typically use or share your health information in the following ways:
• Treat you. We can use your health information and share it with other professionals who are treating you. An example of this would be a doctor treating you for an injury asks another doctor about your overall health condition.
• Bill for your services. We can use and share your health information to bill and get payment from health plans or other entities. An example of this would be sending a bill for your visit to your insurance company for payment.
• Run our office. We can use and share your health information to run our practice, improve your care, and contact you when necessary. An example would be an internal quality assessment review.

How else can we use or share your health information. We are allowed or required to share your information in other ways – usually to contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.
• Help with public health and safety issues. We can share health information for certain situations, such as: preventing disease, reporting suspected abuse, neglect, or domestic violence, preventing/reducing a serious threat to anyone's health or safety.
• Comply with law. We can share information about you if state or federal law requires is, including the Department of Health and Human Services.
• Do Research. We can use and share information for health research.
• Family and Friends: We may disclose your health information to a family member or friend who is involved in your medical care or to someone who helps pay for your care. We may also use or disclose your health information to notify (or assist in notifying) a family member, legally authorized representative or other person responsible for your care of your location, general condition or death. If you are a minor, we may release your health information to your parents or legal guardians when we are permitted or required to do so under federal and applicable state law.
• Organ and tissue donation requests. We can share information about you to organ procurement organizations
• Medical examiner or funeral director. We can share information with a coroner, medical examiner, or funeral director when an individual dies.
• Worker compensation, law enforcement requests, and other governmental requests. We can share health information for worker compensation claims, law enforcement purposes, with health oversight agencies for activities allowed by law, and other specialized government functions (e.g., military and national security)
• Lawsuits and legal actions. We can share health information in response to court or administrative order, or in response to a subpoena.

When it comes to your health information, you have certain rights, we typically use or share your health information in the following ways:
• Get an electronic or paper copy of your medical information. You have the right to inspect and/or obtain a copy of your medical information maintained in a designated record set. If we maintain your medical information electronically, you may obtain an electronic copy of the information or ask us to send it to a person or organization that you identify. To request to inspect and/or obtain a copy of your medical information, you must submit a written request to our Privacy Officer. If you request a copy (paper or electronic) of your medical information, we may charge you a reasonable, cost-based fee.
• Ask us to correct your medical record. You can ask us to correct health information about you that you think is incomplete or incorrect. We may say "no" to your request, but we'll tell you why in writing within 60 days.
• Confidential communications. You can ask us to contact you in a specific way (for instance home or office phone) or to send mail to a different address for items such as appointment reminders. We will say yes to all reasonable requests.
• Limits on what we use and share. You can ask us NOT to share certain health information for treatment, payment, or operations. We are not required to agree to your request, and if it affects your care, we may say no.
• Accounting of disclosures. You can ask for a list (accounting) of the times we have shared your health information for the prior six years. We will include all disclosures, except those about treatment, payment, and operations. We will provide one accounting for free, but may charge a reasonable, cost-based fee if you ask for another within 12 months.

• Privacy Notice. You can ask and receive a paper copy of this notice at any time.
• Complaint. You can file a complaint if you feel we have violated your rights, with the office at the address below, or you with the Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, SW, Room 509F HHH Bldg., Washington, D.C. 20201, calling 1-877-696-6775, or by visiting: www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

In these cases we will never share your information unless given written permission: Marketing purposes, fundraising, and the sale of information.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may, without prior consent, use or disclose protected health information to carry out treatment, payment, or healthcare operations in the following circumstances:
• If we are required by law to treat you, and we attempt to obtain such consent but are unable to contain such consent; or
• If we attempt to obtain your consent but are unable to do so due to substantial barriers to communicating with you, and we determine that, in our professional judgment, your consent to receive treatment is clearly inferred from the circumstances.

State Law

We will not use or share your information if state law prohibits it. Some states have laws that are stricter than the federal privacy regulations, such as laws protecting HIV/AIDS information or mental health information. If a state law applies to us and is stricter or places limits on the ways we can use or share your health information, we will follow the state law. If you would like to know more about any applicable state laws, please ask our Privacy Officer.

We are required by law to maintain the privacy and security of your protected health information. We will promptly let you know if a breach occurs that may have compromised the privacy and security of your information. This notice is effective as of 2003 and we are required to abide by the terms of the Notice of Privacy Practices. We will not share your information other than described in here unless we receive written authorization. We can change the terms of notice, and any new notices will be available upon request, in our office, and on our website.

If you have any questions or want more information about this notice or how to exercise your health information rights, you may contact our Privacy Officer, Thomas Southam by mail at: 1489 W. Elliot Rd. Suite #101 Gilbert, AZ or telephone at 480-507-9400 . You have the right to exercise any of the actions in the above document, and the Privacy Officer will guide you through the process.

☐ I do NOT authorize any information to be discussed with any family members or friends.
☐ I authorize information about treatment or appointments to be discussed with the following person(s):

_____

_____

I have read and understand the above information.

_____ _____
First Name Last Name Date of Birth

_____ _____
Patient Signature (or Authorized Representative) Date

For office use only

The following patient/authorized representative _____

☐ Refused to sign the Notice of Privacy Practices because _____

☐ Was unable to sign the Notice of Privacy Practices because _____

Insurance and Financial Agreement

DENTAL INSURANCE:
Initial each one

_____ We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE. We cannot guarantee insurance payments. In the event insurance does not pay, the patient is responsible for all remaining charges. *If you would like to know your insurance benefit prior to treatment being started, we will be happy to file a "pre-treatment authorization" with your insurance company. Keep in mind this is still not a guarantee of coverage.

_____ We will bill your insurance as a courtesy, however, it is the patient's responsibility to know and understand their own dental benefits. If insurance does not pay their "estimated amount" within 60 days, we reserve the right to request payment in full from you. The insurance you have is a legal contract between YOU and the Insurance Company. Ultimately, you are responsible for all charges incurred in our office.

_____ Patient's estimated portion is due the day of service. Every attempt will be made to give accurate estimates; however, the final amount will not be determined until the claim has been processed by the insurance company.

_____ In the event an account is sent to collections, the patient agrees to pay all court costs, attorney fee's, collection costs and office expenses incurred.

PAYMENT OPTIONS:
***Cash, Check or Credit Card:** For your convenience, we accept Visa, MasterCard, Discover and AMEX. There is a $25 returned check fee.

***Payment Plans:** Patient may be eligible for in-office financing. We also offer payment plans through Care Credit.

We believe that your time, as well as, all of our patient's time is important. A $75 fee may be charged for appointments cancelled without a 24 hour notice.

I agree with the above conditions.

Print Name: _____ Date: _____

Responsible Party Signature: _____