San Tan Family Dentistry

www.santanfamilydentistry.com
info@santanfamilydentistry.com
4059 W Hunt Highway | Suite 2 • San Tan Valley, AZ 85144-3858
(480)672-2525

Welcome to San Tan Family Dentistry!

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____* (Last) _____* (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:*** ◯ Male ◯ Female **Family Status:*** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date:* _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____* (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____* (Address 1) _____ (Address 2)

_____* (City) _____* (State) ___-____* (Zip Code)

Employer Name: *

_____

_____

How would you prefer to receive communication from us? (Check all that apply)

***By checking these boxes, you request and give express written consent to receive communications from San Tan Family Dentistry through these channels. You understand that these communications are not encrypted and give permission for any member of the staff at San Tan Family Dentistry to leave or send messages, even though they may be accessed or viewed by others. ***

☐ Call ☐ Text ☐ Email

How did you hear about our office? *

◯ Facebook ◯ Google Search ◯ Friend/Family Member Referral ◯ Drive/Walk By
◯ Event ◯ Employee Referral ◯ School Referral Card ◯ Insurance Company
◯ Other

We appreciate and acknowledge referrals!

Please let us know the name of the person who we can personally thank for referring you OR if you chose "Other", please describe. *

_____

_____

*Please enter N/A if above does not apply

Dental Insurance Plan Information

--IF THERE IS NO INSURANCE, PLEASE TYPE NA OR YOUR INFORMATION AS NEEDED--

Dental Insurance ID or SSN #: * _____

Group #: _____

Please enter information for the SUBSCRIBER

Name of Insured: _____ * _____ * ____
Last First MI

Patient's relationship to insured:* ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:* _____

Insured's Birth Date: * _____

SECONDARY INSURANCE- If secondary insurance is applicable, please enter the insurance information (same as required above) here for verification:

_____

_____

Insurance Authorization:

☐ ***By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

HIPAA Acknowledgement and Authorization

I understand that I may inspect or copy the protected health information described by this authorization, and that one will be provided to me at any point by request.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I allow this practice to disclose my Protective Health Information to the following individuals: (This information could include: Name, Diagnosis, Test Results, Images and Account Information.)

PHI Authorization

** BY ENTERING A NAME in the box below, you authorize San Tan Family Dentistry to release to the name(s) listed, until otherwise stated in writing, the patient's Protected Health Information or anything pertaining to patient records, treatment needed, insurance, payments, or concerns.

** BY LEAVING THE BOX BLANK, you DO NOT authorize San Tan Family Dentistry to speak with anyone other than the patient (or guardian if patient is under 18) regarding the patient's Protected Health Information or anything pertaining to patient records, treatment needed, insurance, payments, or concerns.

(DO NOT enter patient's name) Name of Authorized Person and Relationship to Patient:

_____

_____

☐ ***By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Response Date: _____

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Medical & Dental History Form

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

You will be asked to sign this document at your appointment

Patient Name: _____ * _____ * ___ _____
Last First MI Preferred Name

Would you consider yourself to be in fairly good health? * ◯ Yes ◯ No

Please check the box for a YES answer to the following medical questions: *

- ☐ Do you use tobacco of any kind (smoking or chewing)?
- ☐ Do you require the use of corrective lenses (contacts or glasses)?
- ☐ Have you been hospitalized within the last five (5) years due to surgery or illness?
- ☐ Within the last year, have there been any changes to your general health?
- ☐ Are you currently under the care of a specialist due to a specific condition?
- ☐ None of the above apply

Your primary medical doctor's name & phone number:

_____

_____

What is the approximate date of your last medical exam?

_____

_____

Are you currently taking any prescription or non-prescription medications? * ◯ Yes ◯ No

Please list any medications you are currently taking, one medication per line:

_____

_____

_____

_____

Are you currently pregnant? ◯ Yes ◯ No

If Yes, when is the due date? _____

Please indicate if you have experienced any of the following:

- ☐ Allergies- Seasonal
- ☐ Allergy - Hay Fever
- ☐ Allergy - Sulfa
- ☐ Artificial Joints
- ☐ Diabetes
- ☐ Excessive Bleeding
- ☐ Head Injuries
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Ozempic
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Venereal Disease
- ☐ Allergy - Aspirin
- ☐ Allergy - Latex
- ☐ Allergy- Nuts
- ☐ Asthma
- ☐ Dizziness
- ☐ Fainting
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Mental Disorders
- ☐ Pacemaker
- ☐ Rheumatism
- ☐ Tuberculosis
- ☐ hydroxyzine
- ☐ Allergy - Codeine
- ☐ Allergy - Other
- ☐ Anemia
- ☐ Blood Disease
- ☐ EPI
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Jaundice
- ☐ Nervous Disorders
- ☐ Radiation Treatment
- ☐ Sinus Problems
- ☐ Tumors
- ☐ Allergy - Erythro
- ☐ Allergy - Penicillin
- ☐ Arthritis
- ☐ Cancer
- ☐ Epilepsy
- ☐ HIV
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Other
- ☐ Respiratory Problems
- ☐ Stomach Problems
- ☐ Ulcers

Do you have any other conditions or allergies not listed that we should be aware of? * ◯ Yes ◯ No

If yes, please explain. Otherwise, type N/A: *

_____

_____

_____

What is the reason for your dental visit today? *

☐ Full New Patient Exam ☐ Pain/Specific Area Focus ☐ Orthodontics ☐ Second Opinion

Other: _____

When was your last visit to the dentist (if to a different office)?

_____

_____

What did you like best and dislike most about your previous dental office?

_____

_____

Have you ever had complications following dental treatment? * ◯ Yes ◯ No

Please check all that apply:
I/my, *

- ☐ Gums bleed when I brush or floss
- ☐ Currently have teeth causing pain, or have senstivity to hot, cold, biting, or pressure
- ☐ Avoid brushing parts of my mouth
- ☐ Clench or grind my teeth (either consciously or during sleep)
- ☐ Have popping or clicking in my jaw
- ☐ Snore or wake up frequently throughout the night
- ☐ Have loose or missing teeth, or am concerned about teeth loosening
- ☐ Currently have dental implant(s), denture(s), or partial(s)
- ☐ Have trouble getting numb
- ☐ Have had reactions to local anesthetic
- ☐ Have/have had braces or other orthodontic treatment
- ☐ Experience dry mouth
- ☐ Notice an unpleasant taste or odor in my mouth
- ☐ Have been treated for gum disease before
- ☐ Have been told I have bone loss around my teeth
- ☐ Have gum recession
- ☐ Am interested in whitening my teeth
- ☐ None of the above apply

If any of the previous questions are marked, please explain:

_____

_____

_____

If you could change anything about your mouth, teeth, or smile, what would it be? Otherwise, type none. *

_____

_____

_____

☐ ***To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.**

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

☐ ***By checking this box, I acknowledge that I have read and agree to this Authorization.**

Name and relationship to patient (if not the patient)

_____

_____

_____

Response Date: _____

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Dental Practice Financial Policy

****Please read this form in its entirety. You will be asked to sign it at your appointment****

Thank you for choosing San Tan Family Dentistry as your dental care provider. We are committed to providing you with the best dental care available. Please read each section carefully and in its entirety.

We accept the following payment options: Cash, Check, Visa, Mastercard, American Express, Discover, CareCredit.

----Payment Arrangements----
*As a condition of your treatment by this office, payment is due on or before the date of treatment. We always do our best to accommodate our patients and their dental needs. Therefore, we may be able to extend financial arrangement if needed. Any financial arrangements must be made in advance.

----Deposits----
*A deposit of up to 50% of the total treatment cost is required to reserve time with the doctor or hygienist. This amount is determined by the office and based upon your treatment needs, amount of visits, and out of pocket total. This is due at the time of scheduling, with the remainder due at the time of service.

----Cancellation/No Show Policy----
*Our office requires a minimum of 48 hours' notice to cancel your appointment. FOR NOTICE LESS THAN 48 hours, there will be a $50 late cancellation fee PER PROVIDER. In the case of an emergency, please contact the office immediately.

----Collections----
*A charge will be added to your account for any returned checks. You are responsible to pay all costs of collecting, or attempting to collect any debt owed on this account. This includes all attorney's fees, interest fees, and late fees.

Patients with Insurance:

Since your insurance company may not cover all of the costs and fees for treatment and services, payment is due at the time of service for all patient portions of said fees and deductibles. We do not bill for services rendered. All outstanding balances will be due within thirty (30) days.

As a courtesy, we will bill all services rendered to your insurance company on your behalf. Your insurance contract is an agreement between you, your employer (if applicable), and your insurance carrier, and therefore, we cannot speak of their behalf. Please understand that any treatment estimates given are AS A COURTESY and are NOT A GUARANTEE OF PAYMENT from your insurance company.

We do our best to understand your insurance plan and give you accurate estimates, but there may be differences between our what is given and what your insurance company pays. We will assist in resolving complications with your insurance company. However, in the event that there is a difference in payment estimated and payment received, the balance will become the patient and/or guarantor's responsibility.

Patients without Insurance:

For patients without insurance coverage, you will be responsible for payment on of before the day of treatment. We offer an in-house discount plan to assist with fees. Please ask about alternative payment options and arrangements if needed.

☐ ***By checking this box, I acknowledge that I have read, and fully understand and agree to the terms of this Financial Policy. I hereby authorize my insurance company, if applicable, to remit payment to San Tan Family Dentistry, otherwise payable to me.**

Name and relationship to patient (if patient is not the undersigned)

_____

_____

_____

Response Date: _____

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Notice of Privacy Practices

****Please read this form in its entirety. You will be asked to sign it at your appointment****

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The privacy of your health information is important to us.

---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.

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. 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. 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 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.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement
activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

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 written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient 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.

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 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, x-rays, or other similar forms of health information.
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, or letters.)

—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.

* You must 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. You may also request access by sending us a letter to the address at the end of this Notice.

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 6 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.

Restrictions: 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 by 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 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.

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.

Acknowledgement: I, hereby acknowledge that I have read and fully understand the contents of this document, and I have been given the opportunity to ask any and all questions.

Response Date: _____