PATIENT INFORMATION

DATE _____

NAME _____ ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE
LAST FIRST M

SOCIAL SECURITY # _____

ADDRESS _____
STREET APT # CITY STATE ZIP

BIRTHDATE _____ TELEPHONE _____
MONTH DAY YEAR HOME WORK CELL EMAIL

NAME OF EMPLOYER _____ ADDRESS _____

IF FULL-TIME STUDENT, SCHOOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: ☐ PATIENT ☐ GUARDIAN ☐ SPOUSE ☐ FATHER ☐ MOTHER

INSURANCE INFORMATION

MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT
ADULTS - COMPLETE PRIMARY INSURED
DUAL COVERAGE? - ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE, COMPLETE FOR RESPONSIBLE PARTY

LAST FIRST M

STREET CITY STATE ZIP

HOME WORK CELL E-MAIL

BIRTHDAY (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO

SS# SUBSCRIBER # GROUP #

SECONDARY INSURED

LAST FIRST M

STREET CITY STATE ZIP

HOME WORK CELL E-MAIL

BIRTHDAY (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO

SS# SUBSCRIBER # GROUP #

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____

Address _____

City/State/Zip _____

Telephone # _____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all cost of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X _____
Parent or Responsible Party

_____
Date State Driver's License #

Has any member of your family ever been treated in our office?
☐ Yes ☐ No

Whom may we thank for referring you to our office?

_____

METHOD OF PAYMENT

Responsible party currently has as account with this office
☐ Yes ☐ No

☐ Payment in full at each appointment (cash or personal check)

☐ Payment in full at each appointment (☐ Visa ☐ MC ☐ Other)

Card # _____ Exp. Date _____

☐ I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGE

If I do not pay the entire new balance within _____ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of ____% per month (or a minimum charge of $_____ for a balance under $_____) which is an annual percentage rate of ____% applied to the last month's balance. In case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

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DENTAL WORKS www.dentalwork.com

PATIENT NAME _____ DATE _____

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

DENTAL HISTORY

Please Circle

Do you have a specific dental problem? Describe _____ Yes No

Do you have a dental examination on a routine basis? Last visit _____ Yes No

Do you think you have active decay or gum disease? _____ Yes No

Do you brush and floss on a routine basis? Discuss _____ Yes No

Do your gums ever bleed? Discuss _____ Yes No

Do you like your smile? Why? _____ Yes No

Does food catch between your teeth? Any loose teeth? _____ Yes No

Do you want to keep your remaining teeth? _____ Yes No

Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No

Have your past experiences in a dental office always been positive? _____ Yes No

Do you smoke or chew tobacco? Any sores or growths in your mouth? Discuss _____ Yes No

Name of previous dentist? (optional): _____ Yes No

Date of last full-mouth x-rays (18 small films or panoramic): _____ Yes No

MEDICAL HISTORY

Are you under a physician's care now? Why? _____ Who? _____ Phone _____ Yes No

Have you ever been hospitalized or had a major operation? Discuss _____ Yes No

Have you ever had a serious injury to your head or neck? Discuss _____ Yes No

Are you taking any medications, fosamax, aspirin, vitamins, herbals, pills or drugs? What? _____ Yes No

Are you on a special diet? Discuss _____ Yes No

Are you allergic to any medications or substances? Please check box below _____ Yes No

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other _____

Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives Discuss _____ Yes No

Do you now have or have you ever had any of the following? Please check appropriate boxes.
* If yes to any of the starred conditions, please call prior to appointment... premedication may be required.

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease/Surgery *	☐	☐	Anemia	☐	☐	Cancer	☐	☐	Night Sweats	☐	☐	Cold Sores	☐	☐
Heart Murmur *	☐	☐	Excessive Bleeding	☐	☐	X-Ray Treatments (Radiation)	☐	☐	Yellow Jaundice	☐	☐	Fever Blisters	☐	☐
Irregular Heart Beat	☐	☐	Sickle Cell Disease	☐	☐	Chemotherapy	☐	☐	Kidney Problems	☐	☐	Herpes	☐	☐
Angina/Chest Pain	☐	☐	Hemophilia (Bleeding Problem)	☐	☐	Bisphosphonates	☐	☐	Renal Dialysis	☐	☐	Stroke	☐	☐
Heart Attack/Failure	☐	☐	Leukemia	☐	☐	Aredia I.V.	☐	☐	Thyroid Disease	☐	☐	Convulsions	☐	☐
Congenial Heart Disorder	☐	☐	Recent Blood Transfusion	☐	☐	Zometa I.V.	☐	☐	Parathyroid Disease	☐	☐	Epilepsy or Seizures	☐	☐
Mitral Valve Prolapse*	☐	☐	Swelling of Limbs	☐	☐	Fosamax, Actonel, Boniva	☐	☐	Arthritis/Gout	☐	☐	Fainting or Dizziness	☐	☐
Scarlet Fever	☐	☐	Lung Disease	☐	☐	Stomach, Intestinal Disease	☐	☐	Rheumatism	☐	☐	Glaucoma	☐	☐
Rheumatic Fever *	☐	☐	Breathing Problem	☐	☐	Ulcers	☐	☐	Pain in Jaw Joints	☐	☐	Tumors or Growths	☐	☐
Artificial Heart Valve *	☐	☐	Shortness of Breath	☐	☐	Recent Weight Loss	☐	☐	Cortisone Medicine	☐	☐	Nervousness	☐	☐
Heart Pace Maker *	☐	☐	Frequent Cough	☐	☐	Frequent Diarrhea	☐	☐	Artificial Joint *	☐	☐	Psychiatric Care	☐	☐
Pulmonary Shunt	☐	☐	Hay Fever	☐	☐	Diabetes	☐	☐	Venereal Disease	☐	☐	Alzheimer's Disease	☐	☐
High Blood Pressure	☐	☐	Sinus Trouble	☐	☐	Excessive Thirst	☐	☐	AIDS	☐	☐	Allergies (Medicines)	☐	☐
Low Blood Pressure	☐	☐	Asthma	☐	☐	Hypoglycemia	☐	☐	HIV Positive	☐	☐	Allergies (Pollen/Dust)	☐	☐
Bacterial Endocarditis	☐	☐	Bloody Sputum	☐	☐	Liver Disease	☐	☐	Genital Herpes	☐	☐	Hives or Rash	☐	☐
Unexplained Fever	☐	☐	Emphysema	☐	☐	Hepatitis A (Infectious)	☐	☐	Drug Addiction/Alcoholism	☐	☐	Need Premedication?	☐	☐
Bruise Easily/Blood Disease	☐	☐	Tuberculosis	☐	☐	Hepatitis B or C	☐	☐	Tattoos/Body Piercing	☐	☐	Ever taken fen-phen? *	☐	☐

Have you ever had any other serious illness not checked above? Discuss _____ Yes No

Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or in my medicine change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____

PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed by Doctor _____ Date _____ BP _____ Pulse _____

History Review and Significant Findings _____

MEDICAL HISTORY

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	PULSE	REVIEWED BY
_____	_____	None ☐	_____	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	_____	Dr. _____

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Office Financial Policy

We realize that every person's financial situation is different. For this reason, we have worked very hard to provide a variety of payment options to help you receive the dental care needed to enjoy a healthy and confident smile.

Dental Insurance

We are happy to file forms necessary to see that you receive the full benefits of your coverage; however, we cannot guarantee any estimated coverage. **Unless prior arrangements are made you will be expected to pay the percentage of your responsibility as services are performed**. Please keep in mind that we can only ***estimate*** your portion, your insurance will not give us access to exact dollar amounts. Because the insurance policy is an agreement between you and the insurance company, we will not enter into a dispute with the insurance company over your claim. We will provide information to support the necessity for treatment, which may assist you in recovering your benefit. If your insurance denies the claim or services, your account will become your responsibility.
*Dr. Terry and Mary Ann are happy to accept all insurance companies (as long as you're free to see any dentist you choose) but are only ***In Network*** with Delta Dental Insurance.

Signature_____Date_____

Payment Options

Cash/Check/Debit: We are happy to provide a 5% discount as a courtesy for treatment that exceeds $300.00 and paid in full on appointment date.

Credit Card: For your convenience, we except most major credit cards, however there is not a discount on services paid with credit cards.

Payment Plan: For patients who desire a monthly payment plan, we have made arrangements with **Care Credit**, there are no application fees or down payments and can be arranged interest free. Applications are available from our office or you can apply online at www.CareCredit.com.

If you wish to discuss any other financial arrangement, please let us know and we will make every attempt to assure a comfortable payment schedule for you.

Please sign below to indicate that you understand our policies and wish for us to accept the assignment of benefits from your insurance company.

Signature: _____ Date:_____

Why Do I Need X-rays?

Radiographic or X-ray examinations provide your dentist with an important tool that shows the condition of your teeth, its roots, jaw placement and the overall composition of your facial bones. X-rays can help your dentist determine the presence or degree of periodontal disease, abscesses and many abnormal growths, such as cysts and tumors. X-rays also can show the exact location of impacted and unerupted teeth. They can pinpoint the location of cavities and other signs of disease that may not be possible to detect through a visual examination.

Do all patients have X-rays taken every six months?
No. Your radiographic schedule is based on the dentist's assessment. In most cases, new patients require a full mouth set of X-rays to evaluate oral health status, including any underlying signs of gum disease and for future comparison. Follow-up patients may require X-rays to monitor their gum condition or their chance of tooth decay.

What kind of X-rays does my dentist usually take?
Typically, most dental patients have "periapical" or "bitewing" radiographs taken. Bitewing X-rays typically determine the presence of decay in between teeth, while periapical X-rays show root structure, bone levels, cysts and abscesses.

My dentist has prescribed a "panoramic radiograph." What is that?
A panoramic radiograph allows your dentist to see the entire structure of your mouth in a single image. This X-ray reveals all of your upper and lower teeth and parts of your jaw. It will also show any abnormal growths, such as cysts and tumors.

Why do I need both types of X-rays?
What is apparent through one type of X-ray often is not visible on another. The panoramic X-ray will give your dentist a general and comprehensive view of your entire mouth on a single film, which a Full Mouth Series, periapical or bitewing X-ray cannot show. These X-rays make it easier for your dentist to see decay or cavities between your teeth. X-rays are not prescribed indiscriminately.

Should I be concerned about exposure to radiation?
All health care providers are sensitive to patients' concerns about exposure to radiation. Your dentist has been trained to prescribe radiographs when they are appropriate and to tailor radiographic schedules to each patient's individual needs. By using state-of-the-art technology your dentist knows which techniques, procedures and X-ray films can minimize your exposure to radiation.

I accept recommended x-ray procedures

Signature_____ Date_____

If you refuse or choose to wait on x-rays in our office it is with the understanding that it is in direct opposition to my recommendations. In some cases, I may ask you to seek services at an office that would agree to treat without radiographic examination.

I decline recommended x-ray procedures.

Signature_____ Date_____

Terry Work, DMD - Mary Ann Work, DMD

NOTICE OF PRIVACY PRACTICES

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. This Notice takes effect (04/14/03), and will remain in effect until we replace it.

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 a 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. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0 for each page, $25.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. 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 will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

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, but not before April 14, 2003. 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 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.

Dental Works, PC

Contact Officer: Julie Echtinaw, New Patient Coordinator

Telephone: (480) 391-0099

Address: 9070 E. Desert Cove, A101, Scottsdale, AZ 85260

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

Late Cancellation or Missed Appointments

Our office reserves time for your appointment with the Doctor or Hygienist. When you have a reserved time with our providers of care and do not keep your appointment there is a late cancellation charge. This charged is billed to you if you have cancelled less than 48 hours prior to your appointment. We of course understand there are emergencies or illness and know that this cannot be planned upon - this will always be taken in consideration.

I have read and acknowledge the policy above:

_____

Patient/Guardian Signature

Privacy Policy

I acknowledge that I received the office privacy Policy Notice for **DentalWorks, PC.**

_____

Patient

In case you do not agree to sign this form, our office must indicate why you declined to do so.

Reason for patient's refusal:

_____

Privacy Director's signature:_____ **Date:**_____