DAVIS
DENTISTRY

Patient Information

Date: _____

Patient Name: _____
Last First M (preferred name)

Gender M / F **Marital Status**: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Date of Birth: _____ **Social Security #:** _____**E-Mail Address:**_____

Address:_____
Street Apartment #

_____
City State ZIP

Phone #'s: Home _____ Work _____ Ext_____ Cell _____

INSURANCE

Primary Insurance
Insurance Co. Name _____
Address: _____
Phone #: _____
Group #: _____ID# _____
Insured's Name: _____
Insured's DOB ____/____/___ SS# _____

Secondary Insurance
Insurance Co. Name: _____
Address: _____
Phone #: _____
Group #: _____ID# _____
Insured's Name: _____
Insured's DOB ___/___/___ SS# _____

Referral Information

Whom may we Thank for referring you? :
_____

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment
Employer Name_____

Address:_____
Street City State Zip Code

Emergency Contact Information

Name: _____**Relation to patient**:_____

Home Phone: _____ **Cell:** _____

Medical History

Primary Physician's name_____ **Phone** _____

Date of last physical or office visit _____ **Have you had any illnesses or operations?** [ ] Yes [ ] No

If yes, please describe _____

Are you currently under a physician's care? [ ] Yes [ ] No **If yes, please describe** _____

Have you ever had a blood transfusion? [ ] Yes [ ] No **If yes, approximate date(s)**_____

Are you currently taking Coumadin (warfarin)? [ ] Yes [ ] No **Are you taking Plavix or aspirin?** [ ] Yes [ ] No

Are you currently taking, or have you taken in the past, bisphophonates (fosamax, aredia, boniva, actonel, zometa)? [ ] Yes [ ] No

Have you eve had bacterial endocarditis? [ ] **Yes** [ ] **No If Yes, Approximate date(s)**_____

WOMEN: Are you pregnant? [ ] Yes [ ] No **Nursing?** [ ] Yes [ ] No **Taking birth control?** [ ] Yes [ ] No

Check if you have now, or have had in the past, any of the following: (all must be checked. Even if they are a NO)

Yes/No	Yes/No	Yes/No	Yes/No
[ ] [ ] Abnormal bleeding	[ ] [ ] Chemotherapy	[ ] [ ] Hemophilia	[ ] [ ] Radiation treatment
[ ] [ ] AIDS/HIV positive	[ ] [ ] Circulatory problems	[ ] [ ] Herpes	[ ] [ ] Respiratory disease
[ ] [ ] Anaphylaxis	[ ] [ ] Cough, persistent	[ ] [ ] Hepatitis A, B, or C	[ ] [ ] Scarlet fever
[ ] [ ] Anemia	[ ] [ ] Cough up blood	[ ] [ ] High blood pressure	[ ] [ ] Shingles
[ ] [ ] Angina	[ ] [ ] Diabetes	[ ] [ ] Jaw pain	[ ] [ ] Shortness of breath
[ ] [ ] Arthritis	[ ] [ ] Epilepsy	[ ] [ ] Kidney disease	[ ] [ ] Sub Bacterial Endocarditic
[ ] [ ] Artificial heart valves	[ ] [ ] Fainting	[ ] [ ] Latex allergy	[ ] [ ] Surgical implant
[ ] [ ] Artificial joints	[ ] [ ] Food allergies	[ ] [ ] Liver disease	[ ] [ ] Thyroid Problems
[ ] [ ] Asthma	[ ] [ ] Headaches	[ ] [ ] Material allergies	[ ] [ ] Tobacco use
[ ] [ ] Atopic (allergy prone)	[ ] [ ] Head Trauma	[ ] [ ] Mitral valve prolapse	[ ] [ ] Tonsillitis
[ ] [ ] Back problems	[ ] [ ] Heart murmur	[ ] [ ] Pacemaker	[ ] [ ] Transplants
[ ] [ ] Cancer	[ ] [ ] Heart problems	[ ] [ ] Psychiatric care	[ ] [ ] Ulcer/colitis
[ ] [ ] Chemical dependency	[ ] [ ] Heart surgery/Stent	[ ] [ ] Rapid weight gain/los	

List any medications you are currently taking, if any:

_____

_____

_____

Have you ever had an adverse reaction to any of the following?

[ ] Antibiotics [ ] Dental Anesthetics (Lidocaine/Novocain)

[ ] Aspirin [ ] Penicillin [ ] Other _____

[ ] Codeine [ ] Pain Medications _____

List any allergies: _____

Are there any other conditions about your overall health that we should be informed about?

_____

_____

Dental History

What would you like for us to do for you today?_____**Are you in dental discomfort today?**_____

Former Dentist _____ **Address** _____

Date of last dental care _____ **Date of last x-rays**_____

Check if you have had problems with the following:

[ ] Food collection between teeth	[ ] Sensitivity when biting	[ ] Bleeding gums	[ ] Clicking jaw
[ ] Grinding or clenching of teeth	[ ] Periodontal treatment	[ ] Sensitivity to hot	[ ] Sensitivity to cold
[ ] Loose teeth or broken fillings	[ ] Sensitivity to sweets	[ ] Bad breath	[ ] Sores in mouth
[ ] Dentures, Partials	[ ] Gum disease (parents/self)	[ ] Snoring	[ ] Orthodontics (braces)
[ ] Burning sensations in mouth	[ ] Difficulty opening mouth	[ ] Smoke or chew tobacco	[ ] Oral Surgery
[ ] Pain around ears, eyes, face	[ ] Mouth or head injury	[ ] Stiff neck muscles	

How often do you brush? _____ How often do you floss? _____

How do you feel about the appearance of your teeth? _____

How do you rate your oral health from a scale of 1-10 _____Why? _____

Does having dental treatment make you afraid or nervous? [ ] Yes [ ] No If Yes, Why _____

If you could change anything about your smile, which of the following would you want?

[ ] Whiter Teeth	**[ ]** Close spaces or gaps	**[ ]** Remove silver fillings	**[ ]** Replace old crowns
[ ] Remove Stains/spots on teeth	**[ ]** Fix excess showing of teeth	**[ ]** Have less gums showing	**[ ]** Straighten teeth
[ ] Replace missing teeth	**[ ]** Reshape or resize teeth	**[ ]** Replace chipped teeth	

Have you ever experienced an adverse (bad) reaction during or in conjunction with a medical or dental procedure? _____

If yes, please explain _____

Consent and Policy

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I authorize the insurance company listed in these forms to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions:

For patients with Insurance:

Benefits for dental treatment vary from plan to plan. Additionally, "Out of Network" benefits are subject to deductibles that vary with each plan. In an effort to provide clear communication with our patients, please be advised as follows;

- We are a contracted provider of Delta Dental "Preferred," Guardian Dental, and Cigna Dental. Any other PPO or Indemnity insurance will be considered "Out of Network" and will require payment in "Full" at the time of service. We will be happy to submit the claims on your behalf for reimbursement.
- The contractual agreement for your dental benefits is between you and the insurance company. **We provide billing as a courtesy**.
- For all insurance carriers that we have a contractual agreement with, we will accept the "In Network" benefits outlined on your individual Explanation of Benefits. You will still be responsible for any or all co-pays, deductibles, or co-insurance amounts due in accordance with the explanation of benefits.
- When insurance benefits have been exhausted and/or terminated, you are responsible for any charges incurred.
- In all cases, you will be responsible for non-covered services that are not covered by your dental plan.
- We are limited to the information that is given to us by your insurance company and cannot be held responsible for percentages or benefits estimated**. However, it is your responsibility to know your dental plan coverage**.

Payment Agreement:

- **Payment is due when services are rendered.** Accounts may be assessed a late charge of 1 ½% per month, not to exceed 18% annual interest. If any account is sent to collections a collection fee will be added to your account.
- Should your account be placed in collections, you will be responsible for any and all fees and court costs incurred.

I authorize Dr. Mark Davis and office to release all information necessary to secure the payment of benefits. I have read and agree to be financially responsible for all services performed by Dr. Mark Davis and staff.

Printed Name:_____

Signature:_____ Date _____

Bisphosphonate
IMPORTANT MEDICAL ALERT

A connection between **Fosamax,** and other bisphosphonates, with a serious bone disease called Bisphosphonate Related Osteonecrosis of the Jaw (ONJ) has been found. The research is inconclusive on exactly how bisphosphonates affect ONJ and how frequently the condition is found.

Bisphosphonates are commonly used in tablet form to **prevent and treat osteoporosis** in post-menopausal woman, and older men. They are also used in the treatment of **Paget's Disease**. Stronger forms given orally or intravenously (IV) are commonly used in the **management of advanced cancers** including, but not limited to, lung cancer, breast cancer, prostate cancer, multiple myeloma, and other matastic cancers.

Have you ever taken any of the following bisphosphonates?

Oral Medications:

Yes _____ No _____ Alendronate (Fosamax ®) Merck & Co
Yes _____ No _____ Alendronate (Fosamax Plus D ®) Merck & Co
Yes _____ No _____ Ibandronate (Boniva ®) Roche Laboratories
Yes _____ No _____ Risedronate (Actonel ®) Proctor & Gamble
Yes _____ No _____ Tiludronate (Skelid ®) Sanofi Pharmaceuticals
Yes _____ No _____ Etidronate (Didronel ®) Proctor & Gamble
Yes _____ No _____ Zoledronate (Reclast ®) Novartis (annual infusion)

Have you ever been treated for cancer with chemo therapy in the past? ___ Yes ___ No
(This applies even if the treatments was many years prior)

Intravenous Medications (Chemo therapy):

Yes _____ No _____ Pamidronate (Aredia ®) Novartis
Yes _____ No _____ Zoledronate (Zometa ®) Norartis
Yes _____ No _____ Clondronate (Bonefos ®) Sherling AG

If yes, when? _____
Prescribing Doctor: _____ Phone _____

Signature: _____
Print Name: _____ **Date:** _____

Davis Dentistry

NOTICE OF PRIVACY PRACTICES

This notice takes effect September 2013 and will remain in effect until we replace it. It describes how health information about you may be used and disclosed by our practice and how you can obtain access to this information. Please review it carefully.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. Our privacy practices are developed to meet requirements as specified by law. If the law changes we will amend our privacy practices to reflect the changes in the law. 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 laws, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, inform you of changes in the Notice by getting a new signed copy from you, and we will provide copies of the new Notice upon request. 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you, or to a care provider that is overseeing other health needs you may have.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information, or we could require a 3rd party to aid in collection of unpaid balances that are due.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We will disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities as required by law, including disclosures to: Prevent or control disease, injury or disability; Report child abuse or neglect; Report reactions to medications or problems with products or devices; Notify a person of a recall, repair, or replacement of products or devices; Notify a person who may have been exposed to a disease or condition; or Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your personal health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your personal health information for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your personal health information to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your personal health information in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been

made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your personal health information to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information. It should however be noted that we typically do not participate in research projects and this release is unlikely.

Coroners, Medical Examiners, and Funeral Directors. We may release your personal health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose personal health information to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. By law, we may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving fundraising communications. Our office policy is to NOT fundraise with patient information.

Other Uses and Disclosures of Personal Health Information. If a situation arises that is not covered in the prior sections, we will seek your permission for health information disclosure, unless dictated to do so by law. Your privacy is important to us and we work

hard to secure all patient health information to protect individual privacy.

YOUR HEALTH CARE RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. 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. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you still have the right to receive a printed, or if possible, an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for any explanation of our fee structure. If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your person health information by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request, except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have on file.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we decided it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if you disagree with a decision we made about access to your health information or in response to a request you made to amend or strict 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 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.

Davis Dentistry

34522 N. Scottsdale Rd. Suite 140

Scottsdale, AZ 85266
Ph. (480) 595-1300

Davis Dentistry-HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we ***may not be allowed*** to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** "Patient" / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH/ACCOUNT INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone (when available)
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone (when available)
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

□ Phone Message
□ Text Message
□ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) _____

_____
Signature of Privacy Officer