Dentistry In Oro Valley
10371 N. Oracle Rd.
Suite 101
Oro Valley, AZ 85735
520.575.4084

New Patient Registration Form

PATIENT INFORMATION

First & Last Name: _____ Gender: ◯ Male ◯ Female ◯ Other

Birth Date: _____ Social Security #: _____

Address: _____

City: _____ State: _____ ZIP: _____

Email: _____

Phone Number (home): _____ (mobile): _____ (work): _____

Occupation: _____

Employer: _____

Marital Status: ◯ Married ◯ Single ◯ Widowed

Emergency Contact: _____ Phone: _____

Previous Dentist: _____ Dental Office: _____

How did you hear about us?

◯ I live/work in area ◯ I was referred by _____

◯ Internet ◯ Other _____

SPOUSE INFORMATION

First Name: _____ Last Name: _____

Birth Date: _____ Phone Number: _____

DENTAL INSURANCE INFORMATION

◯ No Dental Insurance

◯ Primary Insurance

Name of Insurance Company: _____ State: _____

Policy Holder Name: _____ Birth Date: _____

Member ID: _____ Group: _____

Name of Employer: _____

Relationship to Insurance holder: ◯ Self ◯ Parent ◯ Child ◯ Spouse ◯ Other _____

SECONDARY DENTAL INSURANCE

Name of Insurance Company: _____ State: _____

Policy Holder Name: _____ Birth Date: _____

Member ID: _____ Group: _____

_____ _____

Patient Signature Date

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New Patient Health History Form

NAME:_____ **DOB:**_____ **DATE:**_____

Gender:_____ **Are you pregnant?:** _____ **Are you nursing?:** _____

Are you taking birth control or hormonal replacement?: _____

Responsible Party

If you are filling out this form on behalf of another person, please state your name and relationship with that person.

Your Name:_____ **Relationship:**_____

Dental Information *(please check yes/no)*

	YES	NO
Do your gums bleed when you brush or floss?		
Are your teeth sensitive to cold, hot, sweets or pressure?		
Is your mouth dry?		
Have you had any periodontal (gum) treatments or deep cleanings? If yes, please provide details of treatment and year of service. _____		
Have you ever had orthodontic (braces) treatment?		
Have you had any problems associated with previous dental treatment? If yes, please provide details. _____		
Are you currently experiencing dental pain or discomfort? If yes, please provide details. _____ _____		
Do you have headaches, earaches or neck pains?		
Do you have any clicking, popping or discomfort in the jaw?		
Do you brux or grind your teeth?		
Do you have sores or ulcers in your mouth?		
Do you use tobacco/nicotine (smoking/vaping, snuff, chew, pouches)?		
Have you ever had a serious injury to your head or mouth? If yes, please provide details. _____ _____		

Approximate date of your last dental exam. _____

What is the primary reason for your dental visit today? _____

How do you feel about your smile? _____

Allergies *(please check all that apply)*

Are you allergic or have you had a reaction to any of the following?

- ◯Dental Anesthetics
- ◯Penicillin
- ◯Codeine or other Narcotics
- ◯Sulfa drugs
- ◯Antibiotics
- ◯Aspirin
- ◯Metals
- ◯Latex
- ◯Other

If YES, please specify your reaction and medication of cause. _____
_____

(continued on back...)

Medical Information *(please check yes/no)*

	YES	NO
Are you under the routine care of a physician? If yes, what is their name and phone number? _____ _____		
Has there been any change in your general health within the past year? If yes, what condition is being treated? _____		
Approximate date of last medical exam. _____		
Have you had a serious illness, operation or been hospitalized in the past 5 years? If yes, what was the illness or problem? _____		
Are you taking any prescription or over the counter medications? If so, please list all, including prescriptions, vitamins, natural/herbal/dietary supplements. _____ _____ _____		
Have you had any problems associated with previous dental treatment? If yes, please provide details. _____ _____		
Are you currently experiencing dental pain or discomfort? If yes, please provide details. _____ _____		
Joint replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If so, please list joints replaced and approximate year. _____ _____		
Has a physician or previous dentist recommended that you ROUTINELY take antibiotics prior to your dental treatment?		
Are you taking any blood thinners?		
Do you use tobacco/nicotine (smoking/vaping, snuff, chew, pouches)?		
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia) for osteoporosis or Paget's disease? If so, please list the year medication was first taken. _____		
Have you been treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia, Zometa, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? If so, please list the year the medication was first taken. _____		
Any history of head or neck radiation treatment?		
Do you have an artificial (prosthetic) heart valve?		
Have you been diagnosed with infective endocarditis?		

Medical Conditions *(please check all that apply)*

- ◯Congenital Heart Disease
- ◯Cardiovascular disease
- ◯Heart murmur
- ◯Mitral valve prolapse
- ◯Abnormal Bleeding
- ◯Heart Attack/Stroke
- ◯Congestive Heart Failure
- ◯Rheumatic Fever
- ◯Pacemakers
- ◯Anemia
- ◯Acid Reflux/Heartburn
- ◯Hepatitis
- ◯Sleep Apnea/Snoring
- ◯Tuberculosis
- ◯Asthma
- ◯Low Blood Pressure
- ◯High Blood Pressure
- ◯Difficulty Breathing
- ◯Cancer/Chemotherapy/Radiation
- ◯Diabetes Type I or II
- ◯Gastrointestinal Disease/Ulcers
- ◯Fainting Spells/Seizures
- ◯Osteoporosis
- ◯Kidney Disease
- ◯Liver Disease
- ◯Thyroid Condition
- ◯Arthritis
- ◯AIDS/HIV
- ◯Sinus Trouble
- ◯Chronic Pain
- ◯Autoimmune Disease
- ◯Neurological Disorder
- ◯Eating Disorder
- ◯Mental Health Disorder
- ◯Drug/Alcohol abuse
- ◯Persistent swollen glands in neck

Do you have any disease, condition, or problem not listed above that you think I should know about? Please provide details as needed. _____

Signature

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of the Patient/Legal Guardian **Date** **Signature of Provider** **Date**

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PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act. This provides a safeguard to my privacy.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your protected Health Information (PHl). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides you certain rights and protections. We balance these needs with our goal of providing quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. ***www.hs.gov***

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the standard procedures within the office for the handling of charts, records, PHI and other documents or information.
2. lt is the policy of this office to remind patients of their appointments. We may do this by telephone, text or email or by any means convenient for you and the practice. We may send other messages informing you of changes to office policy and new technology that you may find informative.
3. The practice utilizes several vendors in the conduct of business, each are required to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your PHI will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify these provisions to better serve the needs of the practice and the patient.
9. You have the right to request restrictions in the use of your PHI and to request change in certain policies within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

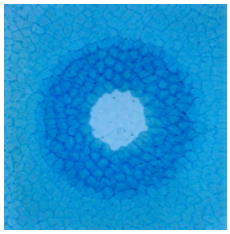
I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA CONSENT FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward. I understand that I have the right to revoke my consent for the use or disclosure of my health information at any time. I may do so by submitting a written request to the dental office. However, I understand that my revocation will not apply to any information that has already been used or disclosed prior to the revocation.

ADDITIONAL AUTHORIZED INDIVIDUALS FOR COMMUNICATION:

Name:_____ **Relationship:**_____ **Phone:**_____

By signing below, I acknowledge that I have had the opportunity to review/ask questions about the office's **Notice of Privacy Practices**. I understand that my PHI will be used and disclosed as outlined in the policy. I consent to the use and disclosure of my PHI as described.

Patient Name:_____ **Signature**: _____



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FINANCIAL and APPOINTMENT POLICY

SELF-PAY PATIENTS: You as the patient assume ALL responsibilities for payment of dental services provided in the office, for yourself and/or dependents. **ALL PAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED.**

DENTAL INSURED PATIENTS: Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract. Insurance billing and verification of eligibility/benefits is done as a COURTESY to our patients. Patients are responsible for co-pays and deductibles. Payment is due at the time services are rendered. Any estimate of what your insurance may cover is not a guarantee of coverage. Your insurance will have final say on what will be paid, stipulations, limitations, and downgrades. Therefore, any balance and/or unpaid claims by your insurance is your responsibility. Unpaid balances on accounts will incur late fees. In the event the account is referred to an attorney or collection agency, the account holder is financially responsible for all fees, costs, and expenses that incur for collection of debt.

FINANCIAL RESPONSIBILITY: I am the person financially responsible for payment due in relation to services provided.

AUTHORIZATION: I authorize my insurance company 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. I authorize the dentist to release all information necessary to secure the payment of benefits.

CONFIRMATION POLICY, MISSED APPOINTMENTS, CANCELLATION AND NO-SHOW:
We require as a courtesy to our team and our scheduled time, that patients give us a 48 hour notice if there should be a conflict with their appointment and they need to reschedule for a different day and time. We send out several text messages, emails, and phone call reminders to ensure you confirm your appointment and are aware of the time booked for you. Should there not be 48 hours notice of your scheduled appointment where you should have a conflict, we reserve the right to charge $50 per appointment per patient canceled or broken in our schedule for that booked time, This fee is NOT refundable. To ensure that we can provide timely care to all of our patients, we kindly request that you provide confirmation of your appointment within 48 hours of the scheduled time. If we do not receive confirmation within this period, your appointment may be released to another patient, and we will offer you an alternative time slot. It is our utmost priority to put our patients first and make each experience a positive one. We thank you for keeping your scheduled appointments and allowing us to put your oral health first and serve you.

PATIENT NAME: _____

SIGNATURE: _____ **DATE:**_____

(Patient/Parent or Legal Guardian if patient is a minor)

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AUTHORIZATION TO RELEASE DENTAL RECORDS

Office: **(520) 575-4084** *Fax:* **(520) 575-1419**
Email: **dentistryinorovalley@dovpractice.com**

Date: _____

Patient Name:_____ **Date of Birth:**_____

Patient Name:_____ **Date of Birth:**_____

Patient Name:_____ **Date of Birth:**_____

Patient Name:_____ **Date of Birth:**_____

Office: _____

_____

_____

I request and authorize the above-named provider's office to release the information specified below to the individual, office or other agency named on this request.

INFORMATION TO BE RELEASED:

_____ FMX _____ BWX _____ PANO _____OTHER

SIGNATURE _____