DENTISTRY IN ORO VALLEY

FRANK EMMERT, DDS IVO SOKOL, DDS

Welcome

Welcome to Dentistry in Oro Valley! Dr. Emmert and Dr. Sokol's goal is to help you reach and maintain maximum oral health. Please fill out this form to the best of your ability. Communication is key to better care for you!

About You

Today's Date: _____

E-mail Address: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called _____ ☐ Male ☐ Female

Birthdate: ___ /___ /___ Age: _____ SS #: _____

Home Address: _____
APT / CONDO #

_____
CITY STATE ZIP

☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Separated**

Hm #: (___) _____ Page / Cell #: (___) _____

Wk #: (___) _____ Ext: ____ DL #: (___) _____

Best Contact #: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Insured's ID #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___ /___ /___

Insured's Employer: _____

Employer's Address: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Insured's ID #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___ /___ /___

Insured's Employer: _____

Employer's Address: _____

Spouse Information

His / Her Name: _____

Employer: _____

Wk #: (___) _____ Ext: ____ SS #: _____

Birthdate: ___ /___ /___ DL #: _____

Person Responsible for Account: _____

Wk #: (___) _____ Ext: ____ Hm #: (___) _____

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

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

His / Her Name: _____ Relation: _____

Wk #: (___) _____ Hm #: (___) _____

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Wk #: (___) _____ Date of last visit: _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Please Explain: _____

CONTINUED ON BACK

Medical History continued

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription / over-the-counter or supplemental drugs? ☐ Yes ☐ No

Please list each one: _____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ Yes ☐ No

Coumadin / blood thinners? ☐ Yes ☐ No

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems? (Please circle option that applies)

Y N	Anemia	Y N	Hepatitis
Y N	Artificial Bones / Joints / Valves	Y N	High Blood Pressure
Y N	Arthritis	Y N	Low Blood Pressure
Y N	Asthma	Y N	HIV+ / AIDS
Y N	Blood Transfusion	Y N	Hospitalized for Any Reason
Y N	Cancer / Chemotherapy	Y N	Kidney Problems
Y N	Congenital Heart Defect	Y N	Mitral Valve Prolapse
Y N	Diabetes	Y N	Psychiatric Treatment
Y N	Difficulty Breathing	Y N	Radiation Treatment
Y N	Drug / Alcohol Abuse	Y N	Rheumatic / Scarlet Fever
Y N	Emphysema / Glaucoma	Y N	Severe / Frequent Headaches
Y N	Epilepsy / Seizures / Fainting Spells	Y N	Shingles
Y N	Fever Blisters / Herpes	Y N	Sickle Cell Disease / Traits
Y N	Heart Attack / Stroke	Y N	Sinus Problems
Y N	Heart Murmur	Y N	Tuberculosis (TB)
Y N	Heart Surgery / Pacemaker	Y N	Ulcers / Colitis
Y N	Hemophilia / Abnormal Bleeding	Y N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y N	Aspirin	Y N	Jewelry / Metals	Y N	Sulfa
Y N	Codeine	Y N	Latex	Y N	Tetracycline
Y N	Dental Anesthetics	Y N	Penicillin	Y N	Other
Y N	Erythromycin				

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? ☐ 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 / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? ☐ Hard ☐ Medium ☐ Soft

Please Acknowledge and Sign

- I understand that the information that I have given today is correct to the best of my knowledge _____ *(please initial)*.
- I also understand that our office is HIPAA Compliant and committed to meeting the standards of infection and control mandated by OSHA, the CDC and ADA _____ *(please initial)*.
- I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent _____ *(please initial)*.
- I understand that payment is due in full at the time of treatment unless prior arrangements have been approved _____ *(please initial)*.

Signature: _____ **Date:** _____

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. **Initials:** _____ **Date:** _____

Doctor's Comments: _____

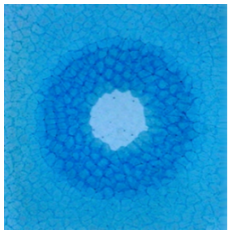
_____

MEDICAL HISTORY UPDATE

1. Date: _____ **Comments:** _____ **Signature:** _____

1. Date: _____ **Comments:** _____ **Signature:** _____

1. Date: _____ **Comments:** _____ **Signature:** _____



Dentistry In Oro Valley

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

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 any 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.

MISSED APPOINTMENTS, CANCELLATION AND NO-SHOW:

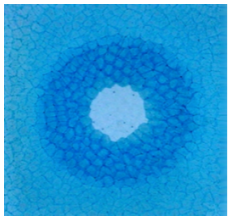
We require as a courtesy to our team and our scheduled time, that patients give us a 48 hour notice if there should be a conflict with their appointment and they need to reschedule for a different day and time. We send out several text messages, emails, and phone call reminders to ensure you confirm 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(s) per patient(s) canceled or broken in our schedule for that booked time, This fee is NOT refundable.

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 continue to put your oral health first and to serve you.

PATIENT: _____

SIGNATURE: _____ **DATE:**_____

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



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AUTHORIZATION TO RELEASE DENTAL RECORDS

Dr. Frank Emmert, DDS **Dr. lvo Sokol, DDS**

Office: **(520) 575-4084** *Fax:* **(520) 575-1419** *Email:* **dentistryinorovalley@gmail.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 _____

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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 certain rights and protections to you as the patient. We balance these needs with our goal of providing you with 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. These vendors may have accessed the PHI and 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 _____ date _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ **Relationship to Patient**: _____