Tatum Ranch Dental Care

29834 N. Cave Creek, Suite 138
Cave Creek, AZ 85331

Date_______________

Name_______________ Date of Birth__________ Male ❑ Female ❑

Address _______________ City__________ State __________ Zip __________

Home Phone __________ Work Phone __________ Cell Phone __________

Email _______________

Occupation _______________ Employer _______________

Parent or Spouse's Name _______________ Their Work Phone _______________

Student Status _______________ Name of School _______________

Who referred you to our office?_______________

Person to contact in case of emergency _______________ Phone _______________

Person responsible for dental investment _______________

For Insurance Purposes:

Name of policy holder __________ Social Security # __________ Date of Birth__________

Relationship to patient __________ Employer __________ Work Phone __________

Insurance Company _______________

Phone Number _______________ Group Number _______________

HIPAA COMPLIANCE STATEMENT

Your health information may be used within our office to conduct scheduling and coordination of care between the doctor, dental assistant, hygienist and business office staff. We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. Your health information may be reviewed during the routine processes of certification, licensing, credentialing activities or auditing for quality assurance.

Communication with our patients is an important part of our philosophy. We prefer to communicate with you directly but we may incorporate the use of phone messages, postcards and letters. We will make every effort to respect your privacy and honor your requests for confidentiality. If you have special needs in regards to privacy issues, please put them in writing for the office so that we may address your concerns.

Patient's Name: _______________

Signature: _______________ Date: _______________

DENTAL HISTORY

Referred by___________________________ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist _______________________________ How long have you been a patient?___________ Months/Years
Date of most recent dental exam ______/______/______ Date of most recent x-rays ______/______/______
Date of most recent treatment (other than a cleaning) ______/______/______
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] ______________ ☐ ☐
2. Have you had an unfavorable dental experience? ______________ ☐ ☐
3. Have you ever had complications from past dental treatment? ______________ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? ______________ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? ______________ ☐ ☐
6. Have you had any teeth removed? ______________ ☐ ☐

SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth that you would like to change? ______________ ☐ ☐
8. Have you ever whitened (bleached) your teeth? ______________ ☐ ☐
9. Have you felt uncomfortable or self conscious about the appearance of your teeth? ______________ ☐ ☐
10 Have you been disappointed with the appearance of previous dental work? ______________ ☐ ☐

BITE AND JAW JOINT

11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ______________ ☐ ☐
12. Do you / would you have any problems chewing gum? ______________ ☐ ☐
13. Do you / would you have any problems chewing bagels, baguettes , protein bars, or other hard foods? ______________ ☐ ☐
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn? ______________ ☐ ☐
15. Are your teeth crowding or developing spaces? ______________ ☐ ☐
16. Do you have more than one bite and squeeze to make your teeth fit together? ______________ ☐ ☐
17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ______________ ☐ ☐
18. Do you clench your teeth in the daytime or make them sore? ______________ ☐ ☐
19. Do you have any problems with sleep or wake up with an awareness of your teeth? ______________ ☐ ☐
20. Do you wear or have you ever worn a bite appliance? ______________ ☐ ☐

TOOTH STRUCTURE

21. Have you had any cavities within the past 3 years? ______________ ☐ ☐
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ______________ ☐ ☐
23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ______________ ☐ ☐
24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? ______________ ☐ ☐
25. Do you have grooves or notches on your teeth near the gum line? ______________ ☐ ☐
26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ______________ ☐ ☐
27. Do you get food caught between any teeth? ______________ ☐ ☐

GUM AND BONE

28. Do your gums bleed when brushing or flossing? ______________ ☐ ☐
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? ______________ ☐ ☐
30. Have you ever noticed an unpleasant taste or odor in your mouth? ______________ ☐ ☐
31. Is there anyone with a history of periodontal disease in your family? ______________ ☐ ☐
32. Have you ever experienced gum recession? ______________ ☐ ☐
33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? ______________ ☐ ☐
34. Have you experienced a burning sensation in your mouth? ______________ ☐ ☐

Patient's Signature ____ Date_______________

Doctor's Signature ____ Date _______________

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MEDICAL HISTORY

Patient Name ______________________________ Nickname ____________________ Age________

Name of Physician/and their specialty ____

Most recent physical examination ______________________________ Purpose ______________________________

What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD: **YES NO**

1. hospitalization for illness or injury____________________
2. an allergic reaction to
   - aspirin, ibuprofen, acetaminophen, codeine
   - penicillin
   - erythromycin
   - tetracycline
   - sulfa
   - local anesthetic
   - fluoride
   - metals (nickel, gold, silver, ___________)
   - latex
   - other ______________________________
3. heart problems, or cardiac stent within the last six months __
4. history of infective endocarditis ____________________
5. artificial heart valve, repaired heart defect (PFO) __________
6. pacemaker or implantable defibrillator ______________
7. artificial prosthesis (heart valve or joints) ______________
8. rheumatic or scarlet fever______________________
9. high or low blood pressure______________________
10. a stroke (taking blood thinners) ____________________
11. anemia or other blood disorder ____________________
12. prolonged bleeding due to a slight cut (INR > 3.5) ________
13. emphysema, shortness of breath, sarcoidosis ___________
14. tuberculosis, measles, chicken pox___________________
15. asthma ____
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)
17. kidney disease ______________________________
18. liver disease ______________________________
19. jaundice ______________________________
20. thyroid, parathyroid disease, or calcium deficiency ________
21. hormone deficiency ________________________
22. high cholesterol or taking statin drugs ______________
23. diabetes (HbA1c =_______) ______________________
24. stomach or duodenal ulcer ______________________
25. digestive disorders (i.e. celiac disease, gastric reflux) _______

YES NO

26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __
27. arthritis, rheumatoid arthritis, lupus ______________
28. glaucoma______________________________
29. contact lenses ______________________________
30. head or neck injuries ____________________________
31. epilepsy, convulsions (seizures) __________________
32. neurologic disorders (ADD/ADHD, prion disease) _______
33. viral infections and cold sores ____________________
34. any lumps or swelling in the mouth________________
35. hives, skin rash, hay fever__________________________
36. STI / STD ______________________________
37. hepatitis (type ___) ____________________________
38. HIV / AIDS ______________________________
39. tumor, abnormal growth_________________________
40. radiation therapy____________________________
41. chemotherapy, immunosuppressive________________
42. emotional problems ____________________________
43. psychiatric treatment__________________________
44. antidepressant medication ______________________
45. alcohol / street drug use ______________________

ARE YOU:

46. presently being treated for any other illness __________
47. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) ____________
48. taking medication for weight management (i.e. fen-phen)
49. taking dietary supplements______________________
50. often exhausted or fatigued ______________________
51. experiencing frequent headaches__________________
52. a smoker, smoked previously or use smokeless tobacco _
53. considered a touchy person ______________________
54. often unhappy or depressed______________________
55. FEMALE - taking birth control pills ________________
56. FEMALE - pregnant ____________________________
57. MALE - prostate disorders ______________________

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ______________________________ Date ______________

Doctor's Signature ______________________________ Date ______________

TATUM RANCH DENTAL CARE FINANCIAL POLICIES

We believe in optimum communications with our patients; therefore, we ask that you please read the following information and ask any questions you may have so that we may help you fully understand our financial policies. Our philosophy in serving patients is to be informative, honest and forthright.

FOR OUR PATIENTS FORTUNATE TO HAVE DENTAL BENEFITS:
Your dental benefits help offset the investment of getting quality dental care and it is our pleasure to assist you in maximizing your insurance benefits. Please be aware that your coverage depends solely on what you or your employer has arranged with the insurance company. We do our best with the insurance information given to us to verify your personal coverage and **estimate** your benefits and co-payments. However, please be aware that the information released by the insurance company to us is very limited and **is not a guarantee of coverage and /or payment**. We strongly advise you to familiarize yourself with your dental coverage benefits (waiting periods, limitations, exclusions, etc.)
We collect **estimated** portions at the time of treatment. The claim will be sent to your insurance company either electronically or by postal delivery. Your **estimated** co-pay may be adjusted after the time of treatment depending upon the reconciliation of insurance payment. If your dental plan pays more than expected you will receive a prompt reimbursement. If your dental plan pays less than expected you will receive a statement reflecting your remaining balance and it is due upon receipt.

Treatment estimates are not a guarantee. Please understand that the entire bill is ultimately your responsibility. We do not base out treatment recommendations on what the insurance company will cover but rather on what is the best treatment for you.

FINANCIAL AGREEMENT (FOR ALL PATIENTS):
Fees are based on treatment anticipated at the initial examination. Some teeth may have hidden decay, fractures, affected nerves or other unanticipated conditions requiring more extensive dental treatment. In situations where additional charges are involved, we will explain the reasons for the treatment and financial costs associated with it. Upon acceptance of treatment the patient/guardian* assumes financial responsibility for payment of the fees. Payment for treatment is due when services are rendered. *The parent/ guardian accompanying a minor into the office is responsible for payment at the time of treatment. We will not attempt to bill a parent that is not present at the time of treatment.

We accept cash, checks, debit cards, flex spending accounts and most credit cards. We also offer C***are Credit Financing.*** An application may be filled out in the privacy of your home or in our office. Applications can be found online at www.carecredit.com.

Returned checks will result in a 40.00 charge, in addition to the balance of the account. Cash or money order will be required.

In the event it should be necessary to place your account in the hands of an attorney or collection agency, you will be responsible to pay all costs of collection, including attorney's fees.

I have read and understand the above policies. I acknowledge full responsibility for the payment of services rendered by Tatum Ranch Dental Care. I authorize release of any information pertaining to treatment for the purpose of filing insurance claims. I authorize payment of primary insurance benefits directly to the dental office. I understand that insurance coverage is a contractual arrangement between me and my insurance company.

X____ Date:________________
(Patient or Parent/Guardian signature)

X ____
(Print patient's name)

HIPAA Notice of Privacy Practices

Revised to reflect the 2013 HIPAA/HITECH Omnibus Final Rule

This Notice describes how health information about you may be used and disclosed and how you can get access to this information. This Notice provides you with information to protect the privacy of your confidential health care information, hereafter referred to as protected health information (PHI). The Notice also describes the privacy rights you have and how you can exercise those rights. Please review it carefully.

If you have any questions about this Notice, please contact our office.

This Notice is effective on September 23, 2013.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the

highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health

Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release 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 also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities

authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to our office. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our office.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our office.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our office. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes

and such information you wish to restrict pertains solely to a health care item or service for which you have paid us “out-of-pocket” in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to our office. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site. To obtain a paper copy of this notice, contact our office.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our office. All complaints must be made in writing. You will not be penalized for filing a complaint.

You may contact our office at:

The Plans may change the terms of this Notice at any time. If the Plans change this Notice, the Plans may make the new Notice terms effective for your entire PHI that the Plans maintain, including any information the Plans created or received before we issued the new Notice. If the Plans change this Notice, the Plans will make it available to you.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.
****You May Refuse to Sign This Acknowledgement****

I, ____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name: ____

Signature: _______________________________________

Date: _________________________________

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself. I, _________________________, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

____
Please Print Name and Relationship

____
Please Print Name and Relationship

____
Please Print Name and Relationship

For Office Use Only
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____Individual refused to sign

____Communications barriers prohibited obtaining the acknowledgement

____An emergency situation prevented us from obtaining acknowledgement

____Other (Please Specify)