2014/05/01

Excel Dentistry

Thank you for visiting Excel Dentistry. We want your visit to be pleasant and comfortable. Please help us by **completing** this form.

A. Patient Information

Name _____
LAST FIRST MIDDLE INITIAL PREFERRED NAME

Address _____
STREET APT #

_____
CITY STATE ZIP

Birth date _____ ❑ **Male** ❑ **Female**

Phone: Home _____

Work _____ May we contact you at work? ❑ Yes ❑ No

Mobile _____ Receive appointment reminders by text? ❑ Yes ❑ No

Email: _____ Receive appointment reminders by email? ❑ Yes ❑ No

Emergency Contact: _____ _____ _____
NAME PHONE RELATION

B. Insurance – *Skip to Section C if you brought your insurance card*

Primary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Secondary Dental Carrier (United Concordia, Cigna PPO, MetLife, United Concordia, Delta Premiere, Delta Dental of AZ, Only)

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

C. Insurance Authorization (Sign & Date)

If there is dental insurance, 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 costs and dental treatment.

☆ _____ **Date** _____
PATIENTS SIGNATURE (or parent/guardian if patient is under 18)

If Patient is Under 18:

Responsible Party _____ Relation to Patient _____

Address (If different from above) _____

Telephone _____

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FIRST NAME_____**LAST NAME**_____ **BIRTHDATE**_____

D. If you are a NEW patient:

How did you hear about us? _____ What is the reason for today's visit? _____

Is there anything you would like to change about your smile? _____

Why did you leave your last dentist? _____ When was your last dental visit? _____

E. Medical History and Information- Complete this Section ANNUALLY

Conditions

(Check Yes/No for each)

Y	N	
□	□	Abnormal Bleeding
□	□	Alcohol Abuse
□	□	Allergies
□	□	Anemia
□	□	Angina Pectoris
□	□	Arthritis
□	□	Artificial Heart Valve
□	□	Asthma
□	□	Blood Transfusion
□	□	Cancer
□	□	Chemotherapy
□	□	Colitis
□	□	Congenital Heart Defect
□	□	Diabetes, if yes: Type 1 or 2?
□	□	Difficulty Breathing
□	□	Drug Abuse
□	□	Emphysema
□	□	Epilepsy
□	□	Facial Surgery
□	□	Fainting Spells
□	□	Fever Blisters
□	□	Frequent Headaches
□	□	Glaucoma
□	□	HIV+ Aids
□	□	Heart Attack
□	□	Multiple Sclerosis

Y	N	
□	□	Heart Murmur
□	□	Heart Surgery
□	□	Hemophilia
□	□	Hepatitis A
□	□	Hepatitis B
□	□	Hepatitis C
□	□	High Blood Pressure
□	□	Joint Replacement
□	□	Kidney Problems
□	□	Liver Disease
□	□	Low Blood Pressure
□	□	Mitral Valve Prolapse
□	□	Pace Maker
□	□	Psychiatric Problems
□	□	Radiation Therapy
□	□	Rheumatic Fever
□	□	Seizures
□	□	Sexually Transmitted D.
□	□	Shingles
□	□	Sickle Cell Disease
□	□	Sinus Problems
□	□	Stroke
□	□	Thyroid Problems
□	□	Tuberculosis
□	□	Ulcers

Allergies □ None

- ❑ Aspirin
- ❑ Amoxicillin
- ❑ Codeine
- ❑ Dental Anesthetics
- ❑ Erythromycin
- ❑ Latex
- ❑ Metals
- ❑ Penicillin
- ❑ Sulfa
- ❑ Tetracycline

Other _____

Y	N	
❑	❑	Do you Smoke or use Tobacco?

If Female

Y	N	
❑	❑	Are you taking Birth Control Pills?
❑	❑	Are you pregnant? If yes, # of weeks
❑	❑	Are you nursing?

Please list any medications you are currently taking: _____

_____

F. Treatment Authorization (Sign & Date)- Complete this section annually

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. **Payment for all treatment and services rendered are my responsibility.**

☆ _____ _____

PATIENTS SIGNATURE (or parent/guardian if patient is under 18) DATE

Excel Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse To Sign This Acknowledgement

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

Printed Name of Patient

☆

Signature (Parent or guardian if patient is under 18)

Date

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

□ Communication barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented us from obtaining acknowledgement

□ Other (Please specify)

Excel Dentistry

FINANCIAL AND CANCELLATION POLICY

Thank you for choosing Excel Dentistry to be your dental care provider. At Excel Dentistry we are committed to providing you with the best care possible. We would like our patients to be informed of our office financial policy prior to any dental treatment.

Payment in full is due at the time of service. If you have dental benefits; your portion for your dental investment will be due in full at the time of service. We do not make any exceptions to this policy for any patients under any circumstances.
The adult who accompanies a minor to an appointment is responsible for payment at the time of service.

We accept the following forms of payment: Cash, Check, Visa, MasterCard, Discover Card, American Express, and Care Credit.
Checks that are returned to our office from your financial institution are subject to a $45.00 returned check fee. Outstanding balances older than 90 days may be subject to finance charges and referred to an outside collection agency.

Insurance: If you have dental insurance, you must bring proof of insurance and we will be happy to submit your insurance claims for you. However, please understand:

- Your insurance is a contract between you, your employer and the insurance company. We are not a party in that contract.
- Not all services are covered benefits in all contracts. Some insurance companies select certain services they will not cover.
- Please update our office staff with any changes to your dental insurance policy.

We must emphasize that as dental care providers, our relationship is with you, the patient, not your insurance company. The balance incurred at our office is your personal responsibility regardless of your insurance company's payment and coverage. Coverage amounts vary from policy to policy, and it is your responsibility to seek coverage amounts and limits of liability on your insurance policy. We would be happy to discuss our charges and how they relate to your particular situation. We realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Cancellation Policy
Please provide a **48 hour advanced notice** for any changes or cancellations to your appointment. This allows us the time we initially reserved for you in our schedule to be filled by another patient who may be waiting for this appointment time. We understand that sometimes illness and emergencies occur and we do accommodate for those rare instances. We reserve time in our schedule for you in advance in order to accommodate your busy schedule. We ask that you give us the same consideration when needing to change or cancel your appointment.
If you find it necessary to cancel, please provide 48-hour advanced notice. Without proper notice, you may be charged a **$40 fee which is subject to change without notice.**

Acknowledgement of Financial and Cancellation Policy

I certify that I have read, understood, and agreed to this financial & cancellation policy, and that it applies to myself and any dependents.

☆ _____ _____

SIGNATURE OF RESPONSIBLE PARTY DATE **PRINTED NAME** OF RESPONSIBLE PARTY

2014/05/01

Excel Dentistry

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 April 14, 2003, 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 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. You may also request access by sending us a letter to the address at the end of this Notice.)

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.

Restrictions: 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.