DENTAL HISTORY Name:____DOB:______________

Check the appropriate box if you have ever had or currently have the following:

	Y	N		Y	N		Y	N
Bad breath	☐	☐	**Chewing ice**	☐	☐	**Fever blisters in mouth or on lips**	☐	☐
Grinding/Clenching teeth	☐	☐	**Pain around ear or jaw**	☐	☐	**Cold sores or growths in mouth**	☐	☐
Bleeding or sore gums	☐	☐	**Chewing on one side of mouth**	☐	☐	**Problems with extractions or surgery**	☐	☐
Dry Mouth	☐	☐	**Food collection between teeth**	☐	☐	**Excessive bleeding from an extraction**	☐	☐
Mouth Breathing	☐	☐	**Mouth pain while brushing**	☐	☐	**Orthodontic Treatment (Braces)**	☐	☐
Lip or cheek biting	☐	☐	**Loose teeth or fillings**	☐	☐	**Periodontal Treatment (Gum Surgery)**	☐	☐
Fingernail biting	☐	☐	**Clicking or popping of jaw**	☐	☐	**Dentures? Partial (U/L) Full (U/L)**		☐

Sensitivity to: (circle) cold heat sweets when biting where?____

Reason for today's visit____

Former Dentist:_____________________________________City:________________State:________Zip:__________

Date of last dental visit:_______________Date of last dental x-rays taken:__________ How many and what type?__________________

How often do you: Brush ?_________Floss?__________ Have you ever had an unfavorable reaction to a local anesthetic? _____________

Do you feel nervous about having dental treatment?__________ Do you have pain or any problems anywhere in your mouth?_________

Do you like your smile?__________ Do you feel that it can be improved?____

HEALTH HISTORY

Physician's Name:____Phone:___________________Date of Last visit:________

Check the appropriate box if you have ever had or currently have the following:

	Y	N		Y	N		Y	N		Y	N
AIDS (HIV)	☐	☐	**Arthritis, Rheumatism**	☐	☐	**Glaucoma**	☐	☐	**Swollen neck glands**	☐	☐
Artificial Heart Valve	☐	☐	**Artificial Joints (knee, hip)**	☐	☐	**Headaches**	☐	☐	**Thyroid Problems**	☐	☐
Diet Pills/ Phen-Fen	☐	☐	**Asthma**	☐	☐	**Herpes**	☐	☐	**Tonsillitis**	☐	☐
Heart Murmur	☐	☐	**Back Problems**	☐	☐	**Kidney Disease**	☐	☐	**Tobacco use: smoke ☐ chew ☐**		☐
Heart Problems	☐	☐	**Blood Disease**	☐	☐	**Liver Disease**	☐	☐	**Tuberculosis**	☐	☐
Describe_______________			**Blood Transfusion**	☐	☐	**Low Blood Pressure**	☐	☐	**Tumor/growth on head/neck**	☐	☐
Bisphos meds (fosamax)	☐	☐	**Hepatitis: Type**_____	☐	☐	**High Blood Pressure**	☐	☐	**Ulcer**	☐	☐
Congestive Heart Failure	☐	☐	**Cancer: Type**__________	☐	☐	**MAOI drugs**	☐	☐	**Respiratory Disease (Lung)**	☐	☐
Angina	☐	☐	**Chemotherapy/ Radiation**	☐	☐	**Scarlet Fever**	☐	☐	**Venereal Disease**	☐	☐
Mitral Valve Prolapse	☐	☐	**Circulatory Problems**	☐	☐	**Shortness of Breath**	☐	☐	**Wear contact lenses**	☐	☐
Pacemaker	☐	☐	**Cortisone Treatments**	☐	☐	**Sinus Trouble**	☐	☐	**Weight change, unexplained**	☐	☐
Rheumatic Fever	☐	☐	**Cough, persistent or bloody**	☐	☐	**Skin Rash**	☐	☐	**Women:**		
Alcohol/drug abuse	☐	☐	**Diabetes**	☐	☐	**Special Diet**	☐	☐	**Are you pregnant?**	☐	☐
Anemia	☐	☐	**Epilepsy/ seizures**	☐	☐	**Stroke**	☐	☐	**Are you nursing?**	☐	☐
Fainting or dizziness	☐	☐	**Swelling of feet or ankles**	☐	☐				**Using Birth Control Pills?**	☐	☐

Tobacco use: amount? ____________________ how long?________________

Is there any condition not listed that you have? ____

MEDICATIONS:

Check here if you are not taking any medications ☐

List any medications you are currently taking:
(*Including Vitamins, Herbal medicines*)

____
____
____
____
____
____
____

Pharmacy Name:_________________________________
Phone:_______________________________________

ALLERGIES:

Check here if you have no known allergies ☐

☐ **Aspirin**
☐ **Codeine**
☐ **Erythromycin**
☐ **Latex**
☐ **Local Anesthetic (Novocaine)**
☐ **Motrin**
☐ **Penicillin/Amoxicillin**
☐ **Sulfa**
☐ **Valium**
☐ **Other:**
(*Food or Medicine*)
____
____
____

Blood Pressure:__________
(*OFFICE USE ONLY*)

CONSENT:

The information on this questionnaire is accurate to the best of my knowledge. I understand this information will be used by the dentist to help determine appropriate dental treatment. If there is any change in medical status, I will inform the dentist. The undersigned hereby authorizes the doctor or doctor's staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. Refusal of diagnostic aids at any time will release the doctor of responsibility for early diagnosis. I also authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated.

Patient or Responsible Party (parent/guardian of minor) :____ Date:______________

Doctor's Signature:____ Date:_______________

Ocotillo Dental Care

compassion and quality

3165 South Alma School Road, Suite 26
Chandler, AZ 85248
(480) 855-1994

FINANCIAL POLICY

In order for our staff to attend to your dental health needs on a more personal level, we have written this information guide. We hope it will make it easier to understand our office policy regarding your financial obligation. We will try and bill you at the appropriate time and file your insurance claims for you. My staff and I will strive to have open communications on all financial matters. If you have any questions or problems; please bring them to our attention. We are here to help.

Patient care is our primary goal.

1: For patients with insurance, as a courtesy we will file your insurance claim for you. If we do not have all your insurance information before the day of treatment you will expected to pay for the services in full. You will be expected to pay your annual deductible and at each visit for treatment, any ***estimated*** co-payment, and any portion not covered by your insurance. Please understand that what we collect are only ***estimates*** and ***you are ultimately responsible for any and all of the cost of your dental care***. After your dental claim is paid, you will be billed for the remaining balance.

2: If, after 90 days your insurance company has not paid on your claim, you will be billed for the ***entire balance***. At this point, you will have to contact your insurance company for reimbursement. We will assist in any way possible but your full payment is due and you will have to go to the insurance company to get payment.

3: For all unpaid accounts after the 90 day period a late fee will be billed each month of $39.00 and a finance charge of 2% on all unpaid balances will be accessed per month until the balance is paid in full.

4. Our office reserves appointment times especially for you when you schedule them. If you are unable to make a scheduled appointment with our office, please notify us within 24 hours prior to your appointment, so that we may schedule another patient at that time. If there is less than 24 hour cancellation notification, there will be ***a $50.00 missed appointment charge***.

5: We suggest that you know the limitations of your insurance. If you are limited, by your insurance plan, to a certain number of visits per year or have contractual waiting periods; please keep track of this information. You will be held responsible for payment.

6: We accept MasterCard, VISA, cash, check, and money orders. Any **check returned** from the bank will be subject to a **$45.00 charge** and cash will be required for future visits.

7: In cases of divorce. The person that brings a minor to the office for dental care is responsible for all charges. Ocotillo Dental Care cannot be responsible to get payment from the other parent.

8: All first time visits and emergencies; Full payment is due at the time of service.

9: Please ask our office staff if you have any questions.

I have read, understand, and accept that I am responsible for any and all fees that are incurred by me at Ocotillo Dental Care, P.C.

______________________________ ____________

Patient or Guardian Signature Date

Printed Name __________________________

Ocotillo Dental Care, P.C.

HIPAA PRIVACY FORM 1

Notice Of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

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Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

Ocotillo Dental Care, P.C.

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 03/01/03 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 a 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. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.25 for each page, $20.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

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.

Restriction: 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.

Contact Officer: Dr. Garelick or Office Manager/Privacy Officer

Telephone: 480-855-1994 Fax: ____________

E-mail: ____________

Address: 3165 S Alma School Rd, Suite 26, Chandler, AZ 85248

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Ocotillo Dental Care, P.C.

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.

____
{Please Print Name}

____
{Signature}

____
{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

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

____

____

____

Welcome to Ocotillo Dental Care. Please fill out this form completely and print clearly. If you have any questions we will be glad to help you.

Patient Information:

Today's Date:________________________________

Name:____ Nickname__________________________________

Home Address:____ City:_______________ State:_____Zip:___________- -___________

Sex: M___ F___ Age:_______ Birthdate:__________________ Marital status: Single:____ Married:____ Divorced:____Widowed:____

Patient SS#: _______---_____---_______ Best time and place to reach you:____________________Cell Phone (____)__________________

Occupation:___________________________ Employer:__________________________________Employer phone: (____)_____________

E-mail Address:___________________________ Driver's License#______________________ Home phone (____)_________________

If the patient is a student: School:____ Grade:_________

How did you hear of us? (passed by office, web site, person's name) ____

In case of Emergency, Contact: Name:_________________________________ Relationship:____________Phone:(____)_______________

Account Information:

PERSON RESPONSIBLE FOR THIS ACCOUNT:____Relationship:______________

SS#:_______---_____---_______ Birthdate:___________________ Driver's License #:__________________________

Phone numbers: Home: (____)________________ Work: (____)___________________ Cell: (____)____________________

Occupation:___________________________ Employer:____

Employer Address:____ Employer phone: (____)___________

Insurance:

Name of Insured (PERSON WHO HOLDS THE INSURANCE):____

SS#:_______---_____---_______ DOB:_________________

Relationship to patient:_____________________________Insurance Co.:_____________________________________Grp #:___________

Is patient covered by additional dental insurance? Yes_____ No____

Name:____SS#:_______---_____---_______DOB:______________

Relationship to patient:_____________________________Insurance Co.:______________________________________Grp#:___________

Medical Insurance Company:____SS#:_______---_____---_______Grp#:___________

Name of Insured:____DOB:_______________

Assignment and Release:

I, THE UNDERSIGNED CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE AND ASSIGN DIRECTLY TO Dr. Garelick ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS. I FURTHERMORE UNDERSTAND THAT IF MY ACCOUNT BECOMES DELINQUENT, AND THIS OFFICE TURNS MY ACCOUNT OVER TO A COLLECTION AGENCY, I WILL BE RESPONSIBLE FOR ANY FEES THAT ARE INCURRED IN THE PROCESS, AS WELL AS THE BALANCE OWED.

____

Responsible Party Signature Relationship Date