Desert Sage Family Dental
Patient Registration Form

Today's Date: _____
First Name:_____ Last Name:_____ Middle Initial:____
Preferred Name:_____

Responsible Party: (if someone other than the patient)
Address: _____ City, State, Zip:_____
Home Phone:_____ Work Phone:_____ Cell Phone:_____
Birth date:_____ Social Security #:_____
E-mail:_____
□ Responsible Party is Policy Holder for Patient □ Primary Policy Holder
□ Secondary Policy Holder

Patient Information:
Address: _____ City, State, Zip:_____
Home Phone:_____ Work Phone:_____ Cell Phone:_____
Sex: □ Female □ Male
Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed
Birth date:_____ Social Security #:_____
E-mail:_____
Employment Status:
□ Full Time □ Part Time □ Self Employed □ Retired □ Unemployed
Preferred Pharmacy:_____
Referred By: _____

Emergency Contact:
Name: _____ Relationship: _____
Phone Number: _____

Primary Insurance Information:
Name of Insured: _____ Relationship: ○Self ○Spouse ○Child ○Other
Member ID: _____ Group #: _____
Insured Social Security #: _____ Insured Birth date:_____
Employer: _____ Insurance Company: _____
Address: _____ City, State, Zip: _____

Secondary Insurance Information:
Name of Insured: _____ Relationship: ○Self ○Spouse ○Child ○Other
Member ID: _____ Group #: _____
Insured Social Security #: _____ Insured Birth date:_____
Employer: _____ Insurance Company: _____
Address: _____ City, State, Zip: _____

Medical History

Are you currently under the care of a physician? □ Yes □ No
Physician's Name: _____ Phone Number: _____
Your current physical health is: □ Good □ Fair □ Poor

Please list any conditions you are currently being treated for: _____
_____
_____

Please list and medications you are currently taking or provide a list so we may scan it into your chart: _____
_____
_____

Do you smoke or use tobacco in any form? □ Yes □ No
Have you ever taken Fosamax, Actonel, or Boniva? □ Yes □ No

For Women: Are you taking birth control pills? □ Yes □ No
Are you pregnant? □ Yes □ No Week #: _____
Are you nursing? □ Yes □ No

Have you ever had any of the following disease or medical problems?

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

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

Are you allergic to any of the following:
___ Aspirin ___ Codeine ___ Dental Anesthetic ___ Sulfa ___Erythromycin
___ Jewelry ___ Latex ___ Metals ___Penicillin ___Tetracycline
Other: _____

Dental History

Do you have a specific concern that brings you in today? _____

_____

Do you require antibiotics before dental treatment?	□ Yes □ No
Are you currently in pain?	□ Yes □ No
Have you ever had a problem with previous dental treatment?	□ Yes □ No
Do you now or have you ever had jaw joint pain (TMJ/ TMD)	□ Yes □ No
Are your teeth sensitive to hot or cold liquids or foods?	□ Yes □ No
Have you had any head, neck, or jaw injuries?	□ Yes □ No
Your current dental health is:	□ Good □ Fair □ Poor
Do you like your smile?	□ Yes □ No

What would you change about your smile? _____

_____

Would you like whiter teeth?	□ Yes □ No
Would you like fresher breath?	□ Yes □ No
Do your gums ever bleed?	□ Yes □ No

How many times a day do you brush your teeth? _____

How often do you floss?	□ Daily □ Weekly □ Occasionally □ Never
Do your gums bleed?	□ Yes □ No
Do you use an electric toothbrush?	□ Yes □ No
Do you use a waterpik?	□ Yes □ No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform and necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature Date

Effective date of notice:
NOTICE OF PRIVACY PRACTICES
DESERT SAGE FAMILY DENTAL
2236 W Bethany Home Rd Suite #1
Phoenix, AZ 85015
602-246-2217
602-336-9513

THIS NOTICE DESCRIBES HOW MEDIVAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you native of our privacy practices. This notice describes how we protect your health information and what right you have regarding it.

Treatment, Payment, and Health Care Operations

The most common reason why we use or disclose your health information is for treatment, payments or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills of claims; and collection unpaid amounts (either ourselves or through a collection agency of attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run out office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside out office for these purpose without any special permission. If we need to disclose your health information outside of our office for these reasons, [we will] [we usually will not ask you for special written permissions.

Uses and Disclosures for other Reasons Without Permission

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state to federal law mandates that certain health information be reported for a specific purpose;
- For public health purpose, such as contagious disease reporting, investigation or surveillance; and notice to and from the federal Food and Drug Administration regarding drugs or medical devices;
- Disclosures to government authorities about victims of suspected abuse, neglect or domestic violence;
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or order of courts or administrative agencies;

- Disclosures for law enforcement purpose, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- Uses or disclosures for health related research;
- Uses and disclosures to prevent a serious threat to health or safety;
- Uses and disclosures for specialized government functions, such as for the protections of the president or high ranking government officials; for lawful national intelligence activities; for military purpose; or for the evaluation and health of members of the foreign services;
- Disclosures of de-identified information;
- Disclosures relating to worker's compensation programs;
- Disclosures of a "limited data set" for research, public health. or health care operations;
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;
- [Specify other uses and disclosures affected by state law].

Unless you object, we will also share relevant information about you care with your family or friends who are helping you with your dental care.

Appointment Reminders

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our offices that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you reminder message on your home answering machine or with someone who answers your phone if you are not home.

Other Uses and Disclosures

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The contact of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to some else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

Your Rights Regarding Your Health Information

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to

get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information. We will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. if you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning if this Notice.

Our Notice of Privacy Practices

By law, we must abide by terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any times as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

Complaints

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

For More Information

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Desert Sage Family Dental Notice of Privacy Practices.

Patient Name: _____

Signature: _____

Date: _____

Financial Policy

DESERT SAGE FAMILY DENTAL
2236 W Bethany Home Rd Suite #1
Phoenix, AZ 85015
Phone: 602-246-2217/ Fax: 602-336-9513

Thank you for choosing us as your dental care provider! We welcome you and your family and are committed to providing quality dental care to our patients.

All patients/guarantors are responsible for payment at the time of service, unless prior arrangements have been made.

Payment Methods: We accept cash, Visa, Mastercard, American Express, Care Credit, and Discover.

Insurance: It is the patient's responsibility to know and understand your dental benefits. As a courtesy to our patients, we will submit a claim to your insurance carrier on your behalf. If for any reason your insurance company pays less than estimated, or in the event they pay nothing, the patient is responsible for the unpaid fees.

Deductible and Coinsurance: All deductible and coinsurance payments are due on the date services are rendered.

Financing: We offer an interest free payment plan, through Care Credit, for up to 18 months (to those that qualify through Care Credit). If interested please ask our front office staff for more information.

Collections: Any accounts more than 90 days delinquent will be turned over to a collection agency.

Missed or Canceled Appointments: All reserved time with the dentist or hygienist requires a 48 hour (business day) notice to cancel or re-schedule. If this courtesy is not practiced a fee of $50.00 will apply.

It's the patient's responsibility to notify our office if there is a change of name, insurance coverage, address, or phone number.

I have read and agree to abide by this financial policy

Name: _____
Signature:_____ Date:_____