My Scottsdale Dentist

Patient Name: _____ Date: _____
Last First MI (Preferred Name)

Address: _____
Street Apartment #

_____
City State Zip Code

Birth Date: _____ Gender (circle): M / F Family Status (circle): Single / Married / Other: _____

Spouse/Domestic Partner Name: _____ Tel. No.: _____

Social Security # _____ Driver's License: _____

Phone (Home): _____ (Work): _____ Ext: _____

Cell Phone: _____ Email address _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Clots
- ☐ Blood Disease
- ☐ Cancer Type_____
- ☐ Chemical Dependency
- ☐ Diabetes
- ☐ Dizziness
- ☐ Dry Mouth
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hepatitis A B C
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus / Sjogrens Synd
- ☐ Mental Disorders
- ☐ Multiple Sclerosis
- ☐ Mitral Valve Prolapse
- ☐ Mononucleosis
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnancy** Due date:_____
- ☐ Are you Nursing? _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Smoking or Tobacco use
- ☐ Snoring
- ☐ Stomach Problems
- ☐ Stroke When? _____
- ☐ Thyroid
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other: _____ _____
- ☐ **Do you premedicate before dental treatment?** What medication do you take?
- ☐ _____

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics _____ _____
- ☐ Erythromycin
- ☐ Latex
- ☐ Penicillin _____ _____
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Other _____

List current medications (inc. over the counter):

1. _____
2. _____
3. _____
4. _____

HH Review
_____ Staff
_____ Date

☐ Extensive medications - see chart

Pharmacy Name **Telephone number**

_____ _____

Dental History

Are you currently in pain?	Y	N
Have you ever had full mouth or panoramic x-rays?	Y	N
Have you had gum or periodontal disease?	Y	N
Have you experienced pain in your jaw? TMJ or TMD	Y	N
Do you have clicking or popping in your jaw?	Y	N
Do your gums bleed?	Y	N
Are your teeth sensitive to heat, cold, sweets?	Y	N
If you could change anything about your smile, what would it be?_____		
Have you had orthodontics (braces) before?	Y	N
Have you whitened your teeth before	Y	N

Family or friend not living with you

Name: _____

Telephone: _____

Caregiver contact info: Name _____ Phone #_____

How did you hear about us?

Money Mailer Newspaper Insurance Internet

Referred by: (Patient name)

_____

- ☐ 1-800 Dentist
- ☐ Google Search
- ☐ Dex Knows
- ☐ Yelp
- ☐ Other_____

OVER ➪

• Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

• Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _____

• Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____

• Name of Physician: _____ Phone_____

For Women: Are you taking birth control Pills? **Yes** **No**

• Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Responsible Party Information for Billing Purposes

Name _____ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date _____ Relationship to patient: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone:_____

Address: _____
Street Apartment # City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation:_____

Address: _____
Street City State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's **Employer** Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Tel. Number ( ) _____

I understand that the information I have given today is correct to the best of my knowledge. I also understand 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 Office to submit claims and for the insurance companies to remit payment(s) to the Dental Office.

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles **my insurance company does not cover within 60 days of service.**

_____ _____
Signature of Patient, Parent or Guardian Date

My Scottsdale Dentist Dr. Steven Poulos & Dr. Sid Stevens
9070 E Desert Cove Avenue, Suite 105
Scottsdale, AZ 85260

Financial Policy

May 2016

We provide a professional service at a reasonable fee. **Payment is expected at the time of service and may be made in the following ways:**

Cash or Check
Visa MasterCard American Express Discover Card
CareCredit *(independent financial service company)*

2. **New patients and emergency patients are required to pay for their first visit at the time of Service.**

3. **Insurance Patients:**

   The contractual liability for insurance companies is between the patient and the insurance company....we are an outside third party. Any expected payment from an insurance company is an estimate **only** and a patient is ultimately responsible for any portion not covered by insurance due to policy limitations or exclusions, annual maximum dental benefits reached.

4. **Co-payments for patients with insurance are as follows:**

   Annual deductible for each patient as outlined by insurance policy
   25% payment at the time of services for basic or restorative services
   50% payment at the time of services for major services
   Balance due on dental services not covered by insurance policy.

5. **Monthly Payment Program**

   We have contracted with *CareCredit* to provide a monthly payment program to our patients with or without insurance. Upon approved credit, this service allows you to make equal, monthly payments on large treatment plans or emergency treatment. Some of these plans are interest-free. Please ask our front desk coordinators about details.

   We also offer patients the opportunity to utilize a credit card authorization payment system for their dental treatment. Payments are mutually agreed amounts between the office and the patient. The credit card will be processed on a mutually agreed day.

6. **Monthly statements will be sent to patients/responsible parties for any outstanding account balance.**

   Any account balance not paid within 60 days will be turned over to a collection attorney in which additional fees will be added to the account balance.

7. **Appointments not cancelled within 24 hours may be subject to a charge.**

   Please inform us immediately when an appointment needs to be rescheduled to a better time allowing another patient to fill your appointment time.

POS Reorder # 1025620

Steven H. Poulos, DDS
Sid S. Stevens, DDS

9070 E. Desert Cove Avenue, Suite 105, Scottsdale, AZ 85260, (480) 614-1122

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

Federal and state law requires us to maintain the privacy of your health information. That law also requires us 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 we describe 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 applicable law permits the changes. 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 health care operations. For example:
Treatment: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: 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 uses 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 may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may 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. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence.
- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to an organ procurement organizations;
- to avert a serious threat to health or safety;

- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

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 request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. 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 may–but are not required to–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 more information about fees.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. 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. Contact us using the information listed at the end of this notice for more information about fees.

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). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your requested is not binding unless our agreement is in writing.

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. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment 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 we should amend the information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.
If you believe that:

- we may have violated your privacy rights,
- we made a decision about access to your health information incorrectly,
- our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
- we should communicate with you by alternative means or at alternative locations,

you may contact us using the information listed below. 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.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

The Patient.

Name: _____

Address: _____

Telephone:_____ E-mail: _____

Patient Number:_____ Social Security Number: _____

Acknowledgement of Receipt of Privacy Practices Notice.

I,_____ , acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: _____ Date: _____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name:_____

Relationship to Individual: _____