Minor Patient's Information

Please complete the following confidential information

My Name is:_____
Last First MI Nickname

Home Phone(_____)_____ M____F____ Date of Birth___/___/___ I am _____ years old.

We live at: _____Apt#_____
Street City State Zip

If different than above address
Mailing address:_____Apt#_____
Street City State Zip

I attend _____School & I am in the _____ grade.

I'm a Full time _____ Part time _____ student.

Mom's Information:

Name:_____

Date of Birth____/____/_____

Employer _____

Work# _____XT._____

SS# _____

Dad's Information:

Name:_____

Date of Birth____/____/_____

Employer _____

Work # (_____)_____ XT._____

SS# _____

Additional Information

Who may we thank for referring you? _____

Insurance Information
For the parents to read

Insurance policies are contracts between you and your insurance company. We are happy to assist you with your claim forms and your effort to get appropriate coverage. To avoid misunderstandings regarding health insurances, our professional services are charged directly to you, and you are personally responsible for payment of fees.

Primary Insurance Policy

Insurance Company _____ Insured's Name _____

Insurance Address_____

Insurance Co. Phone# (_____)_____ Insured's SS#_____

Employer_____ Group#_____

Insured's Date of Birth _____/_____/_____ Relationship to Insured_____

Signature of Parent/Insured ----------_____ Date _____/_____/_____

MEDICAL HISTORY

Patient's Name: _____ Date: _____/_____/_____
Physician's Name (MD) _____ Date of Last Visit _______________
Address:_____ Phone# (_____)_____

Has your child had any serious illnesses, operations, or conditions? Yes_____ No_____ If yes, describe _____
_____

Please mark YES or NO for **each** question: (If your child has or has EVER had)

Y	N		Y	N		Y	N		Y	N	
___	___	**Anemia**	___	___	**Diabetes I / II**	___	___	**Liver disease**	___	___	**Stroke**
___	___	**Arthritis**	___	___	**Drug use**	___	___	**Mitral Valve Prolapse**	___	___	**Swollen Feet or Ankles**
___	___	**Artificial Heart valves**	___	___	**Epilepsy**	___	___	**Nervous Problems**			
___	___	**Artificial Joints**	___	___	**Fainting**	___	___	**Pacemaker**	___	___	**Thyroid problems**
___	___	**Asthma**	___	___	**Glaucoma**	___	___	**Persistent Cough**	___	___	**Tobacco Habit**
___	___	**Back Problems**	___	___	**Frequent Headaches**	___	___	**Psychiatric Care**	___	___	**Tonsillitis**
___	___	**Blood Disease**	___	___	**Heart Murmur**	___	___	**Radiation Treatment**	___	___	**Tuberculosis**
___	___	**Cancer**	___	___	**Heart Problem**	___	___	**Respiratory Disease**	___	___	**Ulcer**
___	___	**Chest Pain**	___	___	**Hemophilia**	___	___	**Rheumatic Fever**	___	___	**Venereal Disease**
___	___	**Cortisone Treatments**	___	___	**Hepatitis A / B/ C**	___	___	**Scarlet Fever**			
___	___	**Chemical Dependency**	___	___	**HIV/AIDS**	___	___	**Shortness of Breath**			
___	___	**Chemotherapy**	___	___	**High Blood Pressure**	___	___	**Special diet**			
___	___	**Circulatory Problems**	___	___	**Jaw pain**	___	___	**Swollen Neck Glands**			
___	___	**Cough up blood**	___	___	**Kidney Disease**	___	___	**Frequent thirst or urination**			

Please explain items marked **"YES"**:

BEFORE ANY CLINICAL PROCEDURES, PATIENTS AT RISK OF INFECTIVE ENDOCARDITIS MUST BE PREMEDICATED (antibiotic)

List ***ANY*** medications your child is currently taking:

Allergies: Aspirin_____ Barbiturates_____ Codeine_____ Latex (gloves) _____ Penicillin_____

Local Anesthetics_____ Sulfa Drugs_____ Other _____ *No known Drug Allergies* _____

I hereby authorize the doctors and/or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk. The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any members of her staff responsible for any errors or omissions that I may have made in the completion of this form.

Parent/ Guardian:_____ Date:_______________

Provider's Notes: _____

Signature of Provider: _____ Date: _____\ _____\ _____

ARROWHEAD DESERT DENTAL
CONDITIONS OF TREATMENT

Appointment Policy
We make every effort to run on time for our patients. As a courtesy to other patients, we ask you to please be on time for your appointment. The appointment time you have chosen will be reserved specifically for you. A failed appointment inconveniences three people: 1) The patient who missed the appointment whose needed treatment is delayed. 2) The doctor and staff who have spent time setting up and preparing for treatment and 3) a patient in need who could have used that time. We reserve the right to charge for broken/ missed appointments or appointments cancelled without **48 hours** advance notice. Depending on the appointment, it will be considered a missed appointment if a patient is 15 minutes late or more. This fee is **$50 per scheduled hour**. Two cancellations without 48 hours notice may be cause to discontinue further treatment in the office.

E-mail address for confirmation e-mails: _____
BEST PHONE # TO CALL FOR APPOINTMENT CONFIRMATION: _____

Financial Policy
Our office requires payment in full at the time of service. We offer a few payment options: cash, personal checks, Visa, MasterCard and American Express. We also offer CARE CREDIT, which is a way to finance your dental needs at a reasonable interest rate. If you are interested in this method of payment, please inquire about it with our front office. If your insurance has not paid the FULL BALANCE in 45 days, from the date of service, you are asked to pay the balance in full. A finance charge of 18% APR (1.5% a month) will be added to the total balance on all accounts over 60 days past due. If a check is returned for any reason, there is $25.00 associated with it. All balances must be paid in full before any further appointments are made. Also checks will no longer be accepted from these families/patients. If your account is sent to collections, an additional 35% of your balance will be charged to cover collection fees. Being sent to collections may be cause to discontinue further treatment in the office.

Office Policy
Because of safety concerns and infection control precautions, the doctors request that **only the person receiving treatment be permitted in the treatment area**. For this reason ***we do not allow children in the dental operatories while their parents are undergoing treatment***. **Please plan accordingly so that your child has supervision during your appointments**. We invite parents into the treatment areas after exams, x-rays and/or procedures are completed on their children to address any questions and discuss your child's dental treatment. We appreciate your understanding on this matter. **All children 17 years of age and under scheduled for treatment must have a parent or legal guardian present in the office during their appointment in the waiting room**. Any patients with special needs can make any necessary arrangements with the office manager prior to your appointment.

Cellular Phones
In order to keep appointments on time and as a courtesy to our staff and other patients we request that all cellular phones either be turned off or placed on vibrate when in one of the operatories. If you do place your phone on vibrate we ask that you let it go to your voice mail instead of answering it while in one of the operatories.

Consent to Dental Procedures
Before receiving treatment, you should ask the doctor about the procedure(s) recommended, and ask any questions you may have before you decide whether or not to give your verbal consent for the procedure(s) that are going to be done. All dental procedures involve some risk of unsuccessful results and complications, and no guarantee is made as to the result of treatment. You have the right to be informed of any such risks as well as the nature of the procedure, the expected benefit, and the availability of alternative methods of treatment, including not having the treatment at all. You have the right to consent to or refuse any proposed procedures as any time prior to its performance. At this office, only composite fillings are done. No amalgam or silver fillings are completed.

To keep you more comfortable during treatment you may receive a local anesthetic or possibly a sedative. In rare instances patients have an allergic reaction to the anesthetic, which may require emergency medical attention or find that it reduces their ability to control swallowing foreign objects during treatment. There is also a small risk of nerve damage as a result of a local anesthetic injection. Sedatives may temporarily make you drowsy or reduce your coordination. If you do take a sedative during the dental procedure, you will need assistance getting home.

X-rays

Dental x-rays will be taken as necessary and appropriate for examination, diagnosis, consultation, and treatment procedures.

Dental Records

The records, x-rays, photographs, models and other materials relating to your treatment in the office of Arrowhead Desert Dental are the property of the doctor. You have the right to inspect such materials and to request copies. You may request to have copies of your dental x-rays sent to another health care provider by signing a "Release of Records" form. We reserve the right to charge a fee to cover the expense of duplicating x-rays and other documents.

Limitation of Liability

In case of any liability that arises from any of the services provided here at Arrowhead Desert Dental, our office will only be liable up to the amount collected from patient for the services rendered.

Information Concerning Your Dental Insurance

Dental insurance is one of the most beneficial and most misunderstood areas in dental treatment today. **Dental insurance is a contract between the EMPLOYER and the PATIENT. It has NO CONNECTION at all to the dentist who is providing the dental treatment**. The extent of coverage varies greatly from company to company and sometimes even within a company. It has absolutely NOTHING to do with the level of service provided by the dentist and the fee charged for these services. Patients must realize that professional services are rendered to a person, not to an insurance company. The insurance company is responsible to the patient and the patient is responsible to us. To better understand your benefits, please contact your insurance carrier. Our office makes every effort possible to assist you with your particular insurance coverage. ***Although it is not required, we will prepare and submit your insurance forms free of charge, as a courtesy. However, we cannot guarantee payment by your insurance company and your bill is ultimately your responsibility***. In order to better serve you, please notify us immediately of any changes in your insurance coverage. Most dental insurance plans have deductibles, maximums and only pay for a percentage of services rendered. For some treatment procedures, like cosmetic treatment, they will not cover at all. We ask those of you with dental coverage to remit your estimated portion for services at the time of treatment. Once your insurance company remits their estimated portion to us, you will be sent a bill for any balance that is due. Your estimated portion is strictly an *estimated portion.* We cannot determine how much the insurance company will decide to pay until they have remitted their portion of the services to us. Only at that time, our office will be able to finalize what the patient's portion of the services will be.

I understand these financial policies and authorize Arrowhead Desert Dental to release my personal information to the extent necessary to process insurance claims or transfer information to specialist or other necessary entities.

If at any time you have questions regarding any treatment, fees or services, please discuss them with us promptly and frankly. We will make every effort to avoid a misunderstanding, to rectify an injustice, or to preserve a friendship.

We reserve the right to dismiss any patient from our practice for inappropriate behavior in our office or on the phone.

Your signature on this form certifies that you have read and understand the information provided, that you have received a copy, if requested, and that you accept the terms and conditions described above.

_____ _____ _____

Responsible Party Signature | Printed Name | Date

Arrowhead Desert Dental
Notice of Privacy Practice

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 ____/____/___, 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 at the end of this notice.

USES AND DISCLOSURE 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 for you.

Payment: We may use and disclose your health information to obtain a payment for services we provided for 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 and qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditations, certification, licensing or credentialing activities.

Your Authorization: I 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 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.

Person 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 of r your care, of your location, your general condition or death. If you are present, then prior to use or disclosure 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 filed 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, 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.

_____ _____

Signature Date

ARROWHEAD DESERT DENTAL

(For persons other than the legal guardians to bring patient)

To Whom It May Concern:

I, _____, hereby authorize the dental treatment of -

_____, my _____ (relationship to patient). If treatment should require more than an exam and general cleaning, please call me at _____. In my absence, I allow _____(name of person other than parent), my child's _____ (relationship to patient), to act as his/her guardian and give consent to any treatment changes or any emergency treatment.

In case of emergency and I cannot be reached, please call _____.

With my signature below, I understand the AZ State Law that requires a parent or guardian to be present when a dependent who is under 18 years of age is being seen by a dentist or physician. This is a written permission from guardian to dentist authorizing treatment.

DATE: _____

PRINT NAME: _____

SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____