Patient Information *pt 1*

MARANA DENTAL CARE

Name _____

LAST **FIRST** **MIDDLE INITIAL** **MR MRS MS DR**

SEX **M** **F** Birthdate _____ Social Security # _____

Address _____

Mobile # _____ Work# _____ ext._____ Phone#_____

Email _____

Employer _____ Occupation _____

SPOUSE INFORMATION

Name _____

LAST **FIRST** **MIDDLE INITIAL** **MR MRS MS DR**

Person Responsible for Account _____ Employer _____

Mobile # _____ Work# _____ ext._____ Phone # _____

Birthdate _____ Social Security # _____

In the event of an emergency, is there someone who lives with you or near you that we should contact?

His / Her Name: _____ Relationship: _____

Phone # _____ Work# _____ ext._____ Mobile #_____

How did you hear about us? _____

Whom may we thank for referring you? _____

_____

Thank you for choosing our dental office and we look forward to serving your dental needs.
We hope that you will continue to recommend our personalized dental care to your family and friends.

Patient Information *pt 2*

MARANA DENTAL CARE

Patient Name: _____

When you look in the mirror at your smile what would you like to be different? _____

_____

What would you like your teeth to be like in 20 years? _____

What is most important to you concerning you dentistry? _____

DENTAL HISTORY

	YES	NO		YES	NO
Bad Breath	☐	☐	Jaw pain or tiredness	☐	☐
Bleeding Gums	☐	☐	Lip or cheek biting	☐	☐
Blistering on lips or mouth	☐	☐	Loose teeth or broken fillings	☐	☐
Burning Sensation on tongue	☐	☐	Mouth pain when brushing	☐	☐
Chew on one side of mouth	☐	☐	Orthodontic Treatment	☐	☐
Cigarette, pipe or cigar smoking	☐	☐	Pain around ear	☐	☐
Chewing tobacco	☐	☐	Periodontal Treatment	☐	☐
Do you wear dentures or partials	☐	☐	Sensitivity to cold	☐	☐
Dry Mouth	☐	☐	Sensitivity to hot	☐	☐
Fingernail biting	☐	☐	Sensitivity to sweets	☐	☐
Food collection between teeth	☐	☐	Sensitivity when biting	☐	☐
Grinding teeth	☐	☐	Sores or growths in your mouth	☐	☐
Gums swollen or tender	☐	☐	Serious injury to head or mouth	☐	☐

How often do you floss? _____ Date of last Dental Exam? _____

TREATMENT AUTHORIZATION

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility.

Patient *(print name)* _____ Signature _____ Date _____

Parent / Guardian *(print name)* _____ Signature _____ Date _____

Thank you for choosing our dental office and we look forward to serving your dental needs.
We hope that you will continue to recommend our personalized dental care to your family and friends.

Patient Insurance

MARANA DENTAL CARE

PRIMARY DENTAL CARRIER

Name of Insurance _____ Insurance Co. Phone# _____

Subscriber Name _____ Birthdate _____ Social Security # _____

Employer _____ Employer Address _____

Group # (plan or policy #) _____

Relation to patient _____ Employee I.D. _____

SECONDARY DENTAL CARRIER

Name of Insurance _____ Insurance Co. Phone# _____

Subscriber Name _____ Birthdate _____ Social Security # _____

Employer _____ Employer Address _____

Group # (plan or policy #) _____

INSURANCE AUTHORIZATION STATEMENT (SIGN & DATE)

I hereby authorize payment directly to th e Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. 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. The information on this page and the medical history is correct to the best of my knowledge.

Signature _____ Date _____

If patient is under 18 years of age

Responsible Party _____ Relationship to patient _____

Address _____ Best Phone# _____

_____

Thank you for choosing our dental office and we look forward to serving your dental needs.
We hope that you will continue to recommend our personalized dental care to your family and friends.

Health History *pt 1*

MARANA DENTAL CARE

Patient Name: _____ Date: _____

Date of last health care exam: _____ What was this exam for? _____

Have you been hospitalized in the last 5 years? ☐ **YES** ☐ **NO** If yes, reason _____

Are you currently receiving care? ☐ **YES** ☐ **NO** If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____

2. _____

3. _____

4. _____

5. _____

For the following questions choose yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

	YES	NO		YES	NO
Heart Murmur (mitral valve prolapse)	☐	☐	Psychosis / Schizophrenic	☐	☐
Pacemaker	☐	☐	Anxiety Disorder	☐	☐
Abnormal Heart Condition	☐	☐	Eating Disorder	☐	☐
Heart (Surgery,Disease, Attack)	☐	☐	Sore/Enlarged Lymph Nodes	☐	☐
Artificial (Prosthetic) Heart Valve	☐	☐	Previous Biopsies	☐	☐
Previous Infective Endocarditis	☐	☐	Slow-Healing Mouth Sores	☐	☐
Stroke	☐	☐	Hypercalcemia or skeletal effects	☐	☐
Anemia	☐	☐	Recurrent Illnesses	☐	☐
Cancer	☐	☐	Joint Replacement	☐	☐
Chemotherapy	☐	☐	Glaucoma	☐	☐
Diabetes	☐	☐	Abnormal Bleeding from a cut	☐	☐
Hepatitis, Any Form	☐	☐	Unintentional Weight Loss/Gain	☐	☐
Epilepsy / Seizures	☐	☐	Sinus Trouble	☐	☐
HIV Positive /AIDS Related Complex	☐	☐	Liver Disease (incl. Jaundice)	☐	☐
Emphysema /other Respiratory Illnesses	☐	☐	Rheumatic Fever	☐	☐
Kidney Disease	☐	☐	Asthma	☐	☐
Serious injury to head or mouth	☐	☐	Recreational Drugs	☐	☐
Drug Addiction	☐	☐	Fainting Spells	☐	☐
			Other infections _____		

Thank you for choosing our dental office and we look forward to serving your dental needs.
We hope that you will continue to recommend our personalized dental care to your family and friends.

Health History *pt 2*

MARANA DENTAL CARE

ARE YOU TAKING ANY OF THESE MEDICATIONS?

	YES	NO		YES	NO
Antacids	☐	☐	Taqamet (Cimetidine)	☐	☐
Herbal Supplements	☐	☐	Blood Thinners	☐	☐

Have you been treated with Fosamax, Actonel, Boniva, Zometa or any other Bisphosphonate Drug? ☐ ☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐

Name of physician or dentist making recommendation: _____ Phone # _____

Do you have any disease , condition, or problem not listed above that you think we should know about?

_____

_____

_____

PLEASE LIST ANY MEDICATION YOU ARE CURRENTLY TAKING:

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

ARE YOU ALLERGIC OR HAVE YOU A REACTION TO:

	YES	NO		YES	NO
Local anesthetics	☐	☐	Valium	☐	☐
Penicillin	☐	☐	Latex Sensitivity	☐	☐
Metals	☐	☐	Codeine	☐	☐
Aspirin	☐	☐	Other Antibiotics	☐	☐
Other Sedative	☐	☐			

Other *(please list)* _____

_____

_____

Thank you for choosing our dental office and we look forward to serving your dental needs.
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Health History *pt 3*

MARANA DENTAL CARE

Patient Name _____ Date: _____

WOMEN Are you pregnant? ☐ **YES** ☐ **NO**

If no, are you planning a pregnancy in the near future? ☐ **YES** ☐ **NO**

Are you a nursing mother ☐ **YES** ☐ **NO**

Are you taking birth control pills? ☐ **YES** ☐ **NO**

Abnormal Blood pressure? ☐ **YES** ☐ **NO** If yes, what is it usually? _____ S _____ /D

Are you a smoker? ☐ **YES** ☐ **NO** If so, how much do you smoke per day? _____

Your current weight? _____

Do you consume soda? *(i.e: Coke, Mountain Dew etc).* ☐ **YES** ☐ **NO** How many per day? _____

Do you consume grapefruit juice, grapefruits or grapefruit extract? ☐ **YES** ☐ **NO**

YOUR DIET Restricted Diet _____

How many meals a day? _____

Food Allergies _____

Sugar in your diet ☐ **NONE** ☐ **SLIGHT** ☐ **MODERATE** ☐ **HIGH**

I have answere d all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you . I will notify the doctor of change in my health and medication.

Patient *(print name)* Signature Date

Doctor *(print name)* Signature Date

DENTAL / MEDICAL UPDATES FOR FUTURE VISITS

DATE	EXCEPTIONS	NONE	PATIENT SIGNATURE	REVIEWED BY

Thank you for choosing our dental office and we look forward to serving your dental needs.
We hope that you will continue to recommend our personalized dental care to your family and friends.

520.616.0790 | MaranaDental.com

Notice of Privacy Practices

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

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, to be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other health care providers or specialists involved in the continuation of your care.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may disclose treatment information when billing a dental plan for your dental services.
- Health Care Operations include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, personal representative, or other individuals to the extent necessary to help with your health care or with payment for your health care. In the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Your protected health information may also be used by our office to recommend treatment alternatives or to provide you with information about health-related benefits and services that may be of interest to you. In addition, we may disclose your health information for public health oversight activities, judicial or administrative proceedings, in response to a subpoena or court order, to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials, and/or to report suspected abuse, neglect, or domestic violence. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which you may exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. lf we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect and copy your protected health information, with limited exceptions. A reasonable fee may be assessed.
- The right to request an amendment to your protected health information. We may deny your request in certain situations.
- The right to receive an accounting of disclosures of protected health information made outside of treatment, payment, or health care operations ...or based on your previous authorization.
- The right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive the notice electronically.

We are required by law to maintain the privacy of your protected health information a n d to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of January 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices,
Privacy Officer
MARANA DENTAL CARE
PO Box 936
13808 N. Sandario Rd,
Marana, AZ 85653
520-616-0790

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
OFFICE OF CIVIL RIGHTS
200 Independence Avenue, S.W.
Washington, D.C.20201
877-696-6775 (toll-free)

Acknowledgment of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly. Obtain payment from third-party payers for my health care services. Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*.

I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient *(print name)* _____ Signature _____ Date_____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgment:_____

_____

FOR OFFICE USE ONLY:

We were unable to obtain the patient's written acknowledgment of our Notice of Privacy Practices due to the following reason:

- ☐ The patient refused to sign
- ☐ Communication barriers
- ☐ Emergency Situation
- ☐ Other_____

Thank you for choosing our dental office and we look forward to serving your dental needs.
We hope that you will continue to recommend our personalized dental care to your family and friends.