# Family Dentistry
...with a gentle touch

Patient Name ________________________________________ Date of Birth_____________________

Mailing Address _________________________________ City/State/Zip _______________________

Email __________________________________________________ Home Phone _________________

Work Phone _____________________________ Cell Phone _________________________________

Marital Status__________ Have we seen other family members? ________________________________

If a Minor, Name of Guardian ____________________________________________________________

Person Responsible for Fee (if other than patient)______________________Relationship ____________

Billing Address (if different from above) ____________________________________________________

Employer _________________________ Work Address & Phone _______________________________

EMERGENCY NOTIFICATION:

Nearest Relative Not Living With You (Name & Phone Number) ________________________________

## INSURANCE INFORMATION

***We will submit your insurance claims for you and estimate your benefits; however, we do not track secondary insurance. Your insurance contract is between you and your insurance company.**

Primary Insurance ______________________________________Group Name & Group #__________

Address _____________________________________________ Phone Number __________________

Subscriber's Name ______________________________Relationship to Patient ____________________

Subscriber ID# _________________________________Subscriber SSN#________________________

Benefit Percentages - Preventative: __________ Restorative: ____________ Major: ________________

Pre-estimate Required _____ Yearly Max.________ Deductible _______ Family Deductible _________

I authorize the release of any information to process my insurance claim.

X________________________________

I hereby authorize payment to the dentist of the insurance benefits otherwise payable to me. A copy of this signature is valid as the original.

X________________________________

## METHOD OF PAYMENT

Please note which method of payment you will be using. as noted, we will bill your insurance for you and estimate benefits. Please choose a method of payment for the remaining balance. You are responsible for any balance not covered by your insurance.

_____________ Cash or check payment in full at time of service (5% discount on treatment plans)

_____ Visa _____ Mastercard _______ Care Credit (Please ask staff for an application for the interest free option.)

*An additional 3% senior citizen (60 years and over) discount will be given if payment is made at time of service with cash, check or credit card. Please be sure to ask for this discount. (For uninsured patients.)*

## MEDICAL/DENTAL HISTORY

*Write the answer to each question in the space provided. In the event a question does not relate to your medical history, write "N/A" (not applicable) in the space provided. *All questions must be answered. If you have a question, please discuss it with the doctor. *Please sign the "Permission to Release Information" as it may be necessary for the dentist to contact your physician.

1. Name, address, telephone of your physician ______________________________________________

______________________________________________________________________________

2. Date of last visit to your doctor and purpose of the visit ______________________________________

______________________________________________________________________________

3. Are you taking any drugs or medications? ____________ If yes, list and describe amounts and purpose

______________________________________________________________________________

NOTE: *there are many drugs and medication incompatibilities, some of which may result in dangerous health problems. Information about your current use of drugs and medications is essential.*

4. Have you ever, or do you now take illegal drugs? _______ If yes, what drugs, and when taken? _______

______________________________________________________________________________

5. Do you have AIDS, or are you HIV-positive? ______________________________________________

If yes, describe and provide current status. _________________________________________________

6. Do you now have, or have you ever had a venereal disease? ________ If yes, describe _______________

7. Have you ever had, or do you now have hepatitis? _______________ If yes, describe _______________

8. For females: Are you pregnant? ___________ If yes, when are you due? _________________________

9. For females: Are you taking birth control pills? ___________________________________________

NOTE: *There are drugs and medications used in routine dental care that decrease the effectiveness of birth control pills.*

10. Have you ever had an allergic reaction to medication? _______ If yes, describe ____________________

______________________________________________________________________________

11. Have you lost weight recently? ______ If yes, describe ________________________________________

### Have You Ever Had or Been Treated For:

12. Rheumatic fever, rheumatic heart disease, heart murmur or congenital heart disease? _______________

13. Heart trouble, heart attack, angina, heart surgery, a pacemaker, or irregular beats? __________________

14. Stomach or intestinal disease? _____ 15. Abnormal blood pressure, excessive bleeding, or anemia?______

16. Breathing problems, asthmas, tuberculosis, or hay fever? _______ 17. Diabetes? __________________

18. Cancer, x-ray treatments or chemotherapy? _____ 19. Kidney problems or renal dialysis? ____________

20. A stroke, convulsions, or fainting spells? __________ 21. Tumors or growths? ______________________

22. Arthritis or rheumatism? ______ 23. Have you ever had a major operation? If yes, describe __________

______________________________________________________________________________

24. Have you ever had a serious injury to your head or neck? If yes, describe _________________________

______________________________________________________________________________

Date of your last visit to a dentist ______________ Do you have any xrays or records? _________________

Reason for your last visit (or series of visits)____________________________________________________

**In respect to any previous dental treatment have you:**

25. Ever fainted? ______ 26. Had an allergic reaction? _______ 27. Had abnormal bleeding? ____________

28. Any other complications during or following dental treatment? If yes, describe ____________________

______________________________________________________________________________________________

29. Do your gums bleed on brushing or eating? ______ 30. Does food catch between your teeth? _________

31. Have your teeth shifted, are there spaces between your teeth now where there were none? _________

Are your teeth flaring or are some of your teeth becoming lose? ______________________________________

32. Are any of your teeth sensitive to heat, cold, or pressure? ______________________________________

33. Do you grind your teeth or clench your jaws? _____________________________________________

34. Do you have pain or clicking in the jaw joint around your ear? ____________________________

35. Have your jaw muscles ever been sore? If yes, describe _________________________________

36. Are there any sores or growths in your mouth? ____________________________________________

37. Do any of your teeth ache? ______________________________________________________________

38. Do you have any other dental complaint? _________________________________________________

**NOTE: A change in your health status should be reported to the office at the earliest possible time.**

To the best of my knowledge, the foregoing questions have been accurately answered.

Permission to Release Health Information.

I grant the right to the dentist to release health information obtained from me, and any information about my dental treatment to third payers, and/or other health practitioners.

Person completing this form:

Signature ______________________________________________________________________

Printed Name __________________________________________________________________

If other than patient, indicate relationship _________________________________ Date _________________

Dentist's History Review & Significant Findings: _____________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

Doctor's Signature _____________________________________________________________ Date ___________

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www.RussDaltonDentistry.com | 8066 E. Florentine Rd., Prescott Valley, AZ 86314

**Medical Information Release Form**

**(HIPAA Release Form)**

Name: ________________________________________

Date of Birth: ___________________________________

**Release of Information**

[ ] authorize the release of information including the diagnosis, records and examination rendered to me and claims information. This information may be released to:

[ ] Spouse ________________________________

[ ] Child(ren) _____________________________

[ ] Other _________________________________

[ ] Information is not to be reased to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

**Messages**

Please call [ ] my home [ ] my work [ ] my cell number: _____________________

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] ______________________________________________

the best time to reach me is (day) __________________

between (time) __________________________________

Signed: _______________________________________ Date _________________

Witness: ______________________________________ Date _________________

**Russel E. Dalton, DMD PLLC, DBA Russ Dalton Dentistry**
**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 protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 3/15/2013, 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 provide the new Notice at our practice location, and we will distribute it 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.

**Your Authorization:** In addition to our use of your health information for the following purposes, 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.

**Security**: You will be notified as soon as possible if the security of your personal health information is breached.

## Uses and Disclosures of Health Information

We use and disclose health information about you without authorization for the following purposes.

**Treatment:** We may use or disclose your health information for your treatment. For example, we may disclose your health information to a physician, pharmacist, 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. For example, we may send claims to your dental health plan containing certain health information.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. For example, 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.

**To You Or Your Personal Representative:** 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 your personal representative, 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 absence or incapacity or in 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.

**Disaster Relief:** We may use or disclose your health information to assist in disaster relief efforts.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization. We will not use your information for fundraising purposes without authorization. We will disclose any financial conflicts of interests that may be involved with your treatment.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Public Health and Public Benefit:** We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

**Decedents:** We may disclose health information about a decedent as authorized or required by law.

**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 the protected health information of an 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).

**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. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we will charge you $0.25 for each page to 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. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of 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.

**Non-disclosure to insurance company**: If you pay out of pocket, in full, for a service or a procedure or service; we will not submit the claim for that service to your insurance company upon your request.

**Electronic Notice:** You may receive a paper copy of this notice upon request.

**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**: Loretta Leiker **Telephone**: (928) 772-2474 **E-mail**: russdaltondentistry@qwestoffice.net