PATIENT INFORMATION

Name:____
LAST FIRST M.I. PREFERRED NAME

(____) ______________________ (____)______________________ (____) ______________________
HOME PHONE WORK PHONE CELL PHONE

Street Address____

City: ________________________ State _______ Zip____________ Employer:______________________________

Social Security #___________________ Birthdate_____/_____/________ Marital Status:________ Sex: ☐M ☐F

E-mail to confirm appointments:____________________________________ May we also text you to confirm? ☐Y ☐N

FINANCIALLY RESPONSIBLE PARTY INFORMATION

Name:____
LAST FIRST M.I. PREFERRED NAME

(____) ______________________ (____)______________________ (____) ______________________
HOME PHONE WORK PHONE CELL PHONE

Relationship to patient:____

Address (if different from above)____

Social Security #__________________ Birthdate_____/_____/________ Marital Status:________ Sex: ☐M ☐F

Employer Name:_____________________________ Is responsible party also a patient at our office? ☐Yes ☐No

REFERRAL INFORMATION

Is this your first visit to our office? ☐Yes ☐No
Please let us know how you learned about our office so we may thank them:

☐ Our website
☐ Yellow Pages
☐ Insurance plan website
☐ Other Patient (name):____
☐ Family member (name):____
☐ Dental Staff (name):____
☐ Other: ____

DENTAL INSURANCE INFORMATION

Does the patient have dental insurance coverage? ☐Yes ☐No; If YES, please complete information below:

Primary Dental Insurance:

Subscriber Name____ Subscriber Date of Birth _______________
Subscriber I.D. or Social Security #____________________ Insurance Company:__________________________
Subscriber Employer_________________________________ Insurance Co. Phone #______________________
Insurance Company Address:____
City/State/Zip____
Group/policy #_____________________________ Patient's relationship to Subscriber______________________

Secondary Dental Insurance:

Subscriber Name____ Subscriber Date of Birth _______________
Subscriber I.D. or Social Security #____________________ Insurance Company:__________________________
Subscriber Employer_________________________________ Insurance Co. Phone #______________________
Insurance Company Address:____
City/State/Zip____
Group/policy # Patient's relationship to Subscriber

CONFIDENTIAL HEALTH HISTORY FORM

Name:____
LAST FIRST M.I.

Person to contact in case of emergency:________________________________ (______)_______________
NAME PHONE

Physician's Name: __________________________ Date of last visit: ___________ Phone: (______)_______________

MEDICAL HISTORY

	YES	NO
1. Have you been hospitalized or under the care of a physician within the last 2 years?	☐	☐
2. Has there been a change in your general health within the past 2 years?	☐	☐
3. Have you been advised by a doctor to take antibiotics prior to dental treatment?	☐	☐
4. Have you ***ever*** taken or been given a biophosphonate medication for osteoporosis or cancer?	☐	☐

Only check ☑ if you have or have ever had any of the following:

- ☐ Chemotherapy
- ☐ AIDS or HIV+
- ☐ Organ Transplant
- ☐ Prescribed Diet Medications
- ☐ Joint Replacements
- ☐ Artificial Heart Valves
- ☐ Infective Endocarditis
- ☐ Repaired or Unrepaired Congenital Heart Defect
- ☐ Cancer
- ☐ Radiation Treatment
- ☐ Profuse Bleeding
- ☐ Anemia
- ☐ Heart Attack
- ☐ Cardiac Pacemaker
- ☐ Stroke
- ☐ Mitral Valve Prolapse
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Asthma/Respiratory Problems
- ☐ Digestive Problems
- ☐ Kidney/Urinary Tract Problems
- ☐ Liver/Hepatitis
- ☐ Nervous Disorders
- ☐ Psychiatric Treatment
- ☐ Epilepsy
- ☐ Substance Abuse
- ☐ Eye Problems
- ☐ Hearing Impairment
- ☐ Hives/Skin Rash
- ☐ Venereal Disease
- ☐ Other- (Physical Impairment)
- ☐ Currently Pregnant
- ☐ Currently Nursing

If you answered YES to any question above, please comment below:

Do you use alcohol? Y/N
How Much:

Do you use tobacco? Y/N
Type/Frequency:

MEDICATIONS

List all medications you are currently taking:

ALLERGIES

List all allergies to any substances, metals, or medications

DENTAL HISTORY

Reason for today's visit:____

Date of last dental care:(approx.)__________________________

Date of last dental x-rays:(approx.)_________________________

Check ☑ if you have any of the following:

- ☐ Sensitivity to cold
- ☐ Sensitivity to biting
- ☐ Sensitivity to hot
- ☐ Tooth pain right now

Any problems associated with previous dental care?_______________________________________

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE ABOVE QUESTIONS ACCURATELY.

____________________	________	____________________	________
DOCTOR'S SIGNATURE	DATE	PATIENT'S SIGNATURE (IF MINOR, PARENT/GUARDIAN SIGNATURE)	DATE

Kent W. Stapley, D.M.D, L.L.C. and Nathan R. Kitchen, D.M.D, P.C.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

TO THE PATIENT: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosers we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we may maintain.

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of the Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I,____________________________, have had a full opportunity to read and consider the consents of the Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out the treatment, payment and health care operations.

Signature:____ Date:________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Patients Name:____

Relationship to Patient:____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patients chart

Kent W. Stapley, D.M.D.   Nathan R. Kitchen, D.M.D., P.C.

1259 North Power Road   Mesa, Arizona 85205

FINANCIAL AGREEMENT

Payment in full for all charges is required at the time of service, unless prior arrangements have been made. If you do not have insurance we accept cash, personal checks, Visa, Mastercard, or Discover card. If you have dental insurance we will collect your insurance co-pay at the time of services. There will be a $20.00 charge for all returned checks.

INSURANCE FILING

As the patient or guarantor, you are ultimately responsible for the full payment of your account, not the insurance company. We do, however, file dental insurance claims and coordinate benefits as a courtesy to you.

We can only make estimates regarding your benefits based on the information you and your insurance company provides us. In the event your insurance company does not pay as much as expected, the remaining balance is due and payable immediately by you.

We understand that patients rely on their dental insurance to help defray the cost of dental services and we will assist you in obtaining your maximum dental insurance benefits. We will counsel with you about what your insurance can do to assist in paying for our services and we will explain any limitations.

DELINQUENT ACCOUNTS

All delinquent accounts (30 days or older) are subject to reasonable service charges and/or legal interest rates. This means we reserve the right to begin charging interest on your account at 1.5% of your unpaid balance per month after a 30 day period.

In the event your account is turned over to a collection agency for non-payment or other delinquency, you will be responsible for payment of any collection costs and/or attorney fees, in addition to the balance owed. Any account turned over to a collection agency forfeits any past special fees and/or discounts. Such special fees and/or discounts will be reversed and you will be responsible for payment of regular fee for procedures at the time of service.

FAILED APPOINTMENTS

Scheduling an appointment is a commitment. Your appointed time has been reserved just for you. Please arrive on time as it may be necessary to reschedule your appointment if you are not.

We make every effort to remind you of upcoming appointments, either by phone or postcard, and ask that you please call back to confirm the appointment date and time.

Failed appointments (less than 24 hours notice) are a significant contributor to rising healthcare costs. Individuals who fail an appointment time reserved for them will be assessed a fee based on the length of the missed appointment.

SIGNATURE

I have completely read and understand the contents of this agreement. I agree to comply with all policies. I hereby assign directly to the dentist named on the insurance claim form any insurance benefits otherwise payable to me. I authorize the release of any information relating to any claims. I understand that I am responsible for payment on any charges not paid by this assignment.

______________________	______________________________________
Date	**Responsible Party Signature**