Welcome to Wigwam Creek Dental Care!

In order to serve you properly, we will need the following information (please print)

All information will be kept strictly confidential

Date:
Update:
Update:

Patient Information and History

A. Patient Name Last: First: Mi.:

Address

(If P.O. Box, please give street address also)

City State Zip

Driver's Lic. # Social Sec. # - - D.O.B. / /

Sex: M ☐ F ☐ Marital Status

Home Phone # ( ) Work Phone # ( ) Ext. #

Cell Phone # ( ) Email Address @

Employer's Name or School Attending:

Closest Relative (not living with you)

Name Phone # Relationship

Emergency Contact (other than spouse)

Name Phone # Relationship

B. Responsible Party Information (Check if same as above) ☐ Social Sec.# - -

Name of Responsible Party D.O.B. Drivers Lic. #

Address Relationship to Patient

Email Address @

Home Phone ( ) Work Phone ( ) Cell Phone ( )

Employer's Name Employer's Phone ( )

Employer's Address

Spouse's Name Work or Cell # ( )

Spouse's Employer's Name Employer's Phone ( )

Employer's Address

If you have dental insurance, please fill-in the following information:

Primary Insurance		**Secondary Insurance**	
Policy Holder's Name		Policy Holder's Name	
Name of Insurance		Name of Insurance	
Address		Address	
Phone ( )	Group #	Phone ( )	Group #
SS #	DOB	SS #	DOB

-over-

D. Referral

Who may we thank for referring you?

- ☐ Insurance Company
- ☐ Patient:
- ☐ Walk-in
- ☐ Yellow Page Ad
- ☐ Physician:
- ☐ Postcard or Mail Piece
- ☐ Sign / Billboard
- ☐ Newspaper (specify) :
- ☐ Other:

E. Payment & Treatment Consent

I authorize the doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to thoroughly diagnose dental needs of _____. I also 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 give my consent to use local anesthetics, relaxants, analgesia ("laughing gas"), antibiotics, or pain medication if deemed necessary for the completion of any dental treatment. I understand that the use of anesthetic agents embodies a certain risk. I also understand that responsibility for payment for dental services provided by this office for myself or my dependents is mine, due and payable at the time services are rendered unless other financial arrangements are made. In the event of default, I (we) promise to pay interest at the rate of 1.5% monthly on the indebtedness, together with all collection costs and reasonable attorney fees as may be required to effect the collection of this note. ***FEES NOT PAID BY THE INSURANCE COMPANY WITHIN 60 DAYS ARE PAYABLE FROM THE PATIENT OR THE RESPONSIBLE PARTY.***

Signature of Responsible Party X Relationship to Patient: Date:

F. Authorization

I hereby authorize my insurance benefits to be paid directly to the doctor's office and also authorize the doctor to release any information to process insurance claims.

Date Signature (insured) X

Date Signature (patient or guardian) X

G. Dental Services Acknowledgement

1. I understand that whenever a tooth is extracted, there is a possibility of infection, bone fracture, temporary paresthesia (numbness) of the lip, gum, tongue and/or facial skin. It is possible, although rare, that the paresthesia would be permanent.

2. I understand that root canal treatment is an attempt to retain a tooth that would otherwise require extraction. Although root canal treatment has a high degree of success, it cannot be guaranteed. Occasionally a tooth undergoing root canal treatment may undergo acute infection. It may require re-treatment, surgery, or (rarely) extraction.

3. I understand that preparation of teeth for crowns, bridges, and fillings may, on occasion, traumatize the pulp (nerve). If the pulp (nerve) is in a weakened condition, this may necessitate a root canal treatment on that tooth in the future.

4. Women taking birth control pills should be aware that antibiotics, such as penicillin or erythromycin, could possibly counteract the effects of the pill and you could become pregnant.

5. I realize that any of the work that the doctor proposes can be performed by a specialist. I will tell the doctor or his staff if I desire that a specialist perform the work.

6. I **do / do not** (circle one) grant permission to take photographs of my mouth or head and neck to used, without revealing my identity, for the furthering of medical and dental knowledge and education.

7. I understand that if I fail to give a 24 hour notice to cancel a scheduled appointment I can be charged a fee up to the amount of the scheduled appointment procedure. I also understand that any X-rays taken are property of the dentist, and that a fee may be charged for any duplication or transfer of said X-rays. I have not taken any mood or mind altering drugs prior to signing this form.

Date Signature X

WIGWAM CREEK DENTAL CARE

13000 W. Indian School Rd, Suite A-7
Litchfield Park, AZ 85340
623-547-0010
FAX 623-935-7109

Welcome to our practice. So that we may provide you with the best possible care, please complete both sides of this medical/dental history form. All information provided is completely confidential.

Patient Name: _____

DENTAL HISTORY

What is the reason for your visit today? _____

_____

Do you have any dental problems now? Yes No

If yes, please explain: _____

_____

Previous dentist's name: _____ Telephone _____

Address: _____ State _____ Zip _____

When was your last comprehensive exam and teeth cleaning? _____

How often do you brush your teeth?_____ How often do you floss? _____

Have you ever had any of the following?

Orthodontic Treatment	Yes	No
Oral Surgery	Yes	No
Periodontal Treatment	Yes	No
Bite splint or occlusal guard	Yes	No
Serious injury to the mouth or head	Yes	No
TMJ treatment	Yes	No

Do you feel nervous about receiving dental treatment ..... Yes No

If so, what is your biggest concern? _____

_____

Are you satisfied with your teeth's appearance? ..... Yes No

If not, what would you do to change it? _____

_____

_____

(Please complete other side)

Patient Name _____

MEDICAL HISTORY

Have you had an allergic or adverse reaction to any medication or substance? ..... Yes No
If yes, please list: _____
Have you been under the care of a medical doctor during the past two years? ..... Yes No
If yes, for what? _____
Physician's Name _____ Phone _____
Address _____ City _____ State _____ Zip _____
Have you taken any medication or drugs during the past two years? ..... Yes No
Are you taking any medications currently? ..... Yes No
If yes, please list name and dosage _____
Have you been a patient in the hospital during the past five years? ..... Yes No
If yes, when and what for? _____
Have you been told by a doctor that you need to be premedicated with antibiotics prior to dental appointment? ..... Yes No
Do you smoke or chew tobacco? Yes No If yes, for how long _____
Women: Are you pregnant? Yes No If yes, when is your due date? _____
Are you currently nursing a child? Yes No Are you taking birth control pills? Yes No

Indicate which of the following you have had, or have at present. Please circle "yes" or "no" to each item.

Heart(Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis (Type: _____)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No
Artificial Heart Valve	Yes	No	Hemophilia	Yes	No	Heart Pacemaker	Yes	No
Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No	Rheumatic Fever	Yes	No
Asthma	Yes	No	Arthritis/Rheumatism	Yes	No	Liver Disease	Yes	No
Latex Sensitivity	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Blood Thinners	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hips, knees, etc)	Yes	No	Chemotherapy	Yes	No	Nervousness/Anxiety	Yes	No
Kidney Trouble	Yes	No	Psychiatric/Psychological Care	Yes	No	Tumors	Yes	No

Please give a brief explanation to any "yes" answer(s) above: _____

Do you have or have you had any disease, condition, or problem not listed? Yes No
If yes, please explain: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

Doctor Signature _____ Date _____

OFFICE USE ONLY

History Review _____

WIGWAM CREEK DENTAL CARE
13000 W. Indian School Rd. Suite A-7
Litchfield Park, AZ 85340
(623) 547-0010

FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT AGREEMENT

Some Insurance Companies do not cover certain procedures that may be requested By the patient or doctor. In the event that this may occur, the patient becomes responsible for the charges incurred. IT IS THE PATIENT'S RESPONSIBILITY TO KNOW WHAT IS AND WHAT ISN'T A COVERED BENEFIT WITH THEIR INSURANCE POLICY. We try to be aware of what coverage each plan offers, but due to the many types of policies, we can't always be aware of all of them. Below is a list of some of the services we find not always covered:

1. Composite material used on fillings of molar teeth.
2. Build-ups in conjunction with crowns.
3. Dentures, partials or flippers due to frequency.
4. Some Laboratory fees in conjunction w/ Oral Pathology.
5. Any services considered "Cosmetic"

IF YOU DECIDE TO HAVE ONE OF THESE OR ANY OTHER SERVICE DONE, AND IT IS NOT COVERED BY INSURANCE, YOU WILL BE RESPONSIBLE FOR ALL CHARGES. WE STRONGLY SUGGEST A PRE- DETERMINATION OF ALL TREATMNT IF YOU HAVE ANY QUESTIONS ABOUT COVERAGE!

I have read the above statement and know that it is my responsibility to know my insurance benefits. In the event that a service is not covered, I agree to pay for all Charges related to the service that was rendered.

I acknowledge that I WILL BE CHARGED $50.00 BY THIS OFFICE, FOR ANY REPEATED MISSED APPOINTMENTS WITHOUT GIVING 24 HOURS NOTICE.

SIGNATURE:_____ DATE:_____

PRINT NAME:_____

WIGWAM CREEK DENTAL CARE, PC

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 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 (MM/DD/YR), 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 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 healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician 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.

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 or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In 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 use or 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.

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 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 filled 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, neglect, 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.

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 of protected health information of 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).

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 obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.___ for each page, $___ per hour for staff time to locate and 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. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

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.}** Your request must specify the alternative means or location, and provide satisfactory explanation 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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Notice of Privacy Practices Acknowledgement

(HIPPA)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly*
- *Obtain payment from third-party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician certifications.*

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time a 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. I also understand 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 Name

Responsible Party (Print) Relationship to Patient

Signature of Responsible Party X Date

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: