PATIENT REGISTRATION

Date:_____

Patient Information

First Name:_____Last Name:_____ Middle Initial:_____

Address:_____City,State,Zip:_____

Cell Phone:_____Work phone:_____Home phone:_____

Sex: Male Female Occupation:_____Preferred Name:_____

E-mail:_____Birthdate:_____SS# :_____

Emergency Name and Contact Phone:_____Relationship:_____

REFERRED BY:_____Previous Dentist:_____

Responsible party

First Name:_____Last Name:_____

Address:_____City, State,Zip:_____

Cell phone:_____Work phone:_____Home phone:_____

Birthdate:_____SS# :_____E-mail:_____

Primary Insurance Information

Name of Insured:_____Relationship to patient: Self Spouse Other

Insured SS# or ID:_____ Insured Birthdate:_____

Employer:_____ Insurance Company:_____

Employer Address:_____ Insurance Address:_____

City, State, Zip:_____ City, State, Zip:_____

Secondary Insurance Information

Name of Insured:_____Relationship to pateint: Self Spouse Other

Insured SS# or ID:_____ Insured Birthday:_____

Employer:_____ Insurance Company:_____

Employer Address:_____ Insurance Address:_____

City, State, Zip:_____ City, State, Zip:_____

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)? If so, how interested are you in stopping? *Circle one:* VERY / SOMEWHAT / NOT INTERESTED	☐	☐	☐
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink i n a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion If yes, date: _____	☐	☐	☐
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐

	Yes	No	DK
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders If yes, specify: _____	☐	☐	☐
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders Specify: _____	☐	☐	☐
Recurrent Infections Type of infection: _____	☐	☐	☐
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation:

Phone: *Include area code*
( )

	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think I should know about? Please explain:	☐	☐	☐

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

MEDICATIONS

CAMELBACK FAMILY DENTAL CARE
DR. HIRPARA & ASSOCIATES

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 Notices takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and applicable law permits the terms of this Notice at any time, provided such changes. 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 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, payments 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 our 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 heath information.

Marketing Heath-Related Services: We will not use your health information for marketing, communication 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 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 authorize federal officials heath 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 expectation. 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 may 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 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 $0.50 for each page, $5.00 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 and alternative format, we will charge a post-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 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 reasonable, cost-based fee for responding to this 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 handle 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 website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about your privacy practices or have questions or concerns, please contact us.
If you are concern 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 heath 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 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: Piyush Hirpara, DDS
Telephone: (602) 864-5010

Camelback Family Dental Care

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I_____, hereby acknowledge that I have received a copy of this office's Notice of Privacy Practices.

I further understand that I have a right to refuse to sign this acknowledgment.

Please Print Name: _____

Signature:_____

Date:_____

We attempted to obtain written acknowledgement of our Notice of Privacy Practices, but could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited
- Other (Please specify)_____

AUTHORIZATION TO LEAVE PATIENT MESSAGES: The HIPPA Privacy Rule permits health care providers to communicate with patients regarding their health. This includes communicating with patients at their home, through the mail, by phone, or in some other manner. A covered entity also may leave a message with a family member or other person who answers the phone when the patient is not at home. THE Privacy Rule permits covered entities to disclose limited information to family members, friends, or other persons regarding an individual's care.

I understand my HIPPA rights and I request that this office of leave messages for me with either of the two individuals listed below or by e-mail, fax, or voice messages at the number listed below.

- **SELF ONLY**: Patient name:_____DOB:_____
  Personal voicemail#:_____Fax:_____
  E-mail:_____
- Name of Relative/Friend and
  phone#:_____
- Name of Relative /Friend and
  phone#_____

Patient/ Legal Guardian Signature: _____**Date:**_____

Camelback Family Dental Care

FINANCIAL POLICY AND AGREEMENT

Thank you for choosing us for your dental needs. We are committed to providing you with excellent care. Our convenient arrangements are based on an open and honest discussion of recommended treatment options, respective fees and patients' financial capabilities.

Payment

Non-Coverage payments are due in full at the time of service, unless prior financial arrangements are made. We do offer several payment options:

- Cash, Check, MasterCard, Visa
- Payment options
- Care Credit

Co-Pays

Co-Payments vary based on your insurance provider. Our friendly staff will be glad to assist you in letting you know what your co-payment amount is for each of your visits.

Insurance

Our office is committed to helping patients maximize their benefits. Some insurance companies require that patients pay for services upfront and then reimburse them for the services rendered. For these scenarios, we will estimate your coverage in good faith, but cannot guarantee these amounts. For those patients that are covered by insurance(s), which pay out the practices directly this will be considered your method of payment.

Collection fees

Fees that are incurred to collect payments will be billed to and payable by the patients account holder.

Financial Consent

The patient (account holder) agrees to be fully responsible for the total payment of the treatment.

With this signature, I hereby understand and agree to this Financial Policy.

Print Patient/ Responsible Party **Signature** **Date**

Camelback Family Dental care

DENTAL APPOINTMENT POLICY

At Camelback Family Dental Care we try our best to service as many people in our community as possible. To do so effectively, we must maintain accurate schedules for patient visits. It is important for patients to keep their scheduled dental appointments so that everyone can see the dentist in a timely manner. Missed appointments results in lost time which could be used to provide great care to others.

Rescheduled Appointments:

We understand that there may be circumstances where you must reschedule an appointment. If you do need to reschedule, please do so as soon as you know that you will **NOT** make it in. Please call **at least 24 Hours in advance at 602.864.5010.**

Missed Appointments:

If you miss an appointment, or cancel it with less than 24 hours notice, a missed appointment will be recorded in your file. If your record indicates that you have acquired missed appointments, a **$25 Non-Refundable** charge will be added to your account. This cancellation fee will have to be paid in-full on your next visit, or no dental services can be provided for you, with the exception of immediate emergencies.

I have read and fully understand the Dental Appointment Policy and agree to follow the terms set forth.

_____

Patient Name (Print) **Signature** **Date**