Red Rock Family Dentistry

Patient Information

Date: _____ **(Please Circle One)** **Male / Female**

Patients Name: _____ _____
Last First MI Preferred Name

Family Status (please circle one): Married Single Child Other

Birth Date: _____ **Social Security #:** _____

Email: _____ **Are you able to receive text messages**? _____

Phone: ( ) _____ ( ) _____ ( ) _____ _____
Home Cell Work Ext

Address: _____ _____ ____ _____
City State Zip Code

Occupation: _____ **Employer**: _____

Whom may we thank for referring you to our office? _____

If not a patient then please list source of referral: _____

Contact in case of an emergency? _____ ( )_____
Name of Contact Phone #

Responsible Party

(If different from above)

Name: _____ ( ) _____
Last First MI Phone #

Address: _____ _____ ____ _____
City State Zip Code

Birth Date: _____ **Social Security #:** _____

Relationship to Patient? (spouse, guardian, etc.) _____

Primary Dental Insurance Information

Insured's Name: _____ _____
Last First MI Insured's Soc. Sec. #

Birth Date: _____ **ID #**: _____

Insurance Company: _____ **Group #**: _____

Insurance Co. Address: _____

Insurance Co. Phone #: ( ) _____

Insured's Employer: _____ **Employer Phone #**: ( ) _____

Patient Dental and Medical History

Name of Previous Dentist and Location: _____ **Date of Last Dental Visit**: _____
How many times a week do you floss? _____ **How many times a day do you brush?** _____
Would you like your teeth whiter? _____ **Do you like your smile?** _____

Please circle "Yes" or "No" to indicate if you have had any of the following:

Gums swollen or tender	Yes	No	Grinding your teeth	Yes	No
Lip or Cheek or Tongue biting	Yes	No	Sores/Growths in your mouth	Yes	No
Bad breath	Yes	No	Jaw Pain	Yes	No
Periodontal Treatment	Yes	No	Loose teeth or broken fillings	Yes	No
Bleeding gums	Yes	No	Sensitivity to sweets	Yes	No
Blisters on Lip or Mouth	Yes	No	Sensitivity to heat / cold	Yes	No
Clicking or popping jaw	Yes	No	Sensitivity when biting	Yes	No
Dry mouth	Yes	No	Burning sensation on tongue	Yes	No
Food collection between teeth	Yes	No	Trauma in mouth	Yes	No
Anxiety	Yes	No			

Physician's Name: _____ **Phone #**: ( ) _____ **Last Visit Date**: _____

Pharmacy Name: _____ **Phone #:** ( ) _____

***Women:** **Are you pregnant?**	**Yes**	**No**
Are you nursing?	**Yes**	**No**
Are you taking Birth Control Pills?	**Yes**	**No**

Please Circle if you are allergic to or had any reactions to:

Ampicillin	Aspirin/Ibuprofen	Augmentin
Latex	Codeine	Sulfa
Percocet	Morphine	Local Anesthetic
Penicillin	Tetracycline	ANY Metals

Please list any other allergies you may have: _____

Are you taking blood thinners? **Yes** **No** **Baby Aspirin?** **Yes** **No** **How often?** _____
Do you need to take antibiotics prior to dental appointments? **Yes** **No**
Have you used bisphosphonate medications such as Actonel, Fosamax or Zometa within the past 12 years? **Yes** **No**
Are you currently taking any prescription or non-prescription medications (If yes, please list): _____

_____

Please Circle "Yes" or "No" to indicate if you have had any of the following:

ADHD	Yes	No	Circulatory problems	Yes	No	Liver Disease	Yes	No
AIDS/HIV	Yes	No	Cortisone Treatments	Yes	No	Mitral Valve Prolapse	Yes	No
Allergies (seasonal)	Yes	No	Cough (persistent/bloody)	Yes	No	Nervous problems	Yes	No
Anemia	Yes	No	Diabetes	Yes	No	Pacemaker	Yes	No
Arthritis	Yes	No	Epilepsy	Yes	No	Psychiatric care	Yes	No
Artificial Heart Valves	Yes	No	Fainting or Dizziness	Yes	No	Radiation Treatments	Yes	No
Artificial Joints	Yes	No	Glaucoma	Yes	No	Respiratory problems	Yes	No
Asthma	Yes	No	Headaches	Yes	No	Scarlet Fever	Yes	No
Back Problems	Yes	No	Heart Murmur	Yes	No	Shortness of breath	Yes	No
Bleeding abnormally			Heart problems	Yes	No	Skin rash	Yes	No
with extractions of surgery	Yes	No	Hemophilia	Yes	No	Stroke	Yes	No
Blood disease	Yes	No	Hepatitis	Yes	No	Thyroid problems	Yes	No
Cancer	Yes	No	Herpes	Yes	No	Tobacco habit	Yes	No
Chemical dependency	Yes	No	High Blood Pressure	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Kidney Disease	Yes	No	Ulcers	Yes	No

Describe any conditions not listed above: _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and records of my treatment or examination rendered to me (or my child) during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist any insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services and agree to be responsible for payment of all services rendered on my behalf or my dependents. In the event that I seek credit from the dental office, I consent to release a copy of my credit report to the dental office.

Signature of Patient: _____ Signature of Doctor: _____

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 01/01/14, 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 $0.10 for each page, $10.00 per hour for staff time 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. 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.

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: Randy Cullmiore or Travis Cullimore

Telephone: (480) 782-8111 **Fax:** (480) 857-2609

E-mail: redrockfamilydentistry@hotmail.com **Address:** 908 W Chandler Blvd Suite C-7, Chandler, Arizona 85225

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002; April 30, 2009).

I, _____ , have received a copy of this office's Notice of Privacy Practices.

(Print Patient Name)

_____ _____

Signature **Date**