P: 602-957-8200 Fax: 602-957-6198
info@arizonabiltmoredentistry.com
www.arizonabiltmoredentistry.com

Who may we thank for referring you to our office? ___________________________________

Patient Information

Patient Name ____
Last middle first

Mailing Address____

City_________________________State_________________________________ Zip_________

Social Security #:____________________ Date of Birth________________ Gender __________

Home Phone_________________Work Phone_________________Cell____________________

E-Mail_________________________ Marital Status __________Spouse Name______________

Occupation____________________________ Employer _________________________________

Employer Address____

Employer Phone ____

Emergency contact ________________________Relationship___________Phone _____________

Insurance Information

Primary Insurance:

Subscriber's Name ____DOB________________

Social Security # ________________ID #_______________Employer _______________________

Name of Insurance Company __________________________Phone_________________________

Insurance Address ____

Secondary Insurance:

Subscriber's Name ____DOB_______________

Social Security # ________________ID #_______________Employer ______________________

Name of Insurance Company __________________________Phone________________________

Insurance Address ____

If patient has third insurance plan please list below

Medical History

1. Any major hospitalizations or surgeries within the last two years? Yes or No
   Explain____
   ____
2. Do you have a Primary Care Physician (s) Yes or No
   Name(s)____
   ____
3. Please list name(s) and dosage or attach list of medications you are taking
   ____
   ____

Drug Allergies____
____

5. Do you have any of the following? Please circle and provide more information if known

Diabetes Heart Disease Heart attack Heart murmur High Blood Pressure Pacemaker Stents Stroke Hepatitis Tuberculosis HIV/AIDS	Arthritis Osteoporosis Bone Disease Artificial Joints Artificial Valves Pregnant Breast Feeding Eye problems Sleep apnea Snoring Seasonal Allergies Sinusitis	Heart Burn Gastric reflux Bleeding Problems Taking Blood thinners Lung, Asthma or Respiratory Disease Thyroid Disease Cancer Seizures Alcoholism Depression Anxiety Mental Illness

____
____
____

Conditions/syndromes/diagnosis not listed? Please explain ___________________
____
____

Dental History

When was your last dental visit? ______________________________________
What kind of treatment was performed at that time?______________________
Have you ever been referred to a specialist?___________________________
Do you have missing teeth?____
Have you ever had a deep cleaning?___________________________________
Are your teeth sensitive?____
Do you have TMJ/TMD? ____
Do you use tobacco products?____
Do you consume alcohol?____
What would make your smile a 10? ____________________________________
What can we do to make your dental experience a pleasant one? ____________
____

By signing below you confirm the information you have provided is accurate to the best of your knowledge

______________________________ ______________________________
Signature Date

Arizona Biltmore Dentistry Office Policy

Welcome to Arizona Biltmore Dentistry. We are here to provide our patients with the best possible, dental care. As your provider, we recommend treatment that is in the best interest of your medical and dental health. Be aware that often insurance companies select certain dental procedures that they may or may not cover regardless of your personal situation, health, and dental needs. The following is an overview of our office financial policy.

Insurance: Dental Insurance rarely pays for 100% of all dental services. ***As a courtesy***, we will bill your dental insurance for your care, providing you give us the needed information for claim submission. Your estimated co-pays are due at time of service and any balance unpaid after the claim settles is due within 14 days of receipt of statement. **Initials__________**

Payment from the insurance company is expected within thirty (30) days. If your insurance company has not responded within a sixty (60) days grace period from the date of service, the remaining balance in full is your responsibility. At the time of service, we will request from you an initial payment; this is an estimated portion of the charges which insurance may not cover, including all applicable deductibles and co-pays**.** **Initials___________**

Copyright: Any comment posted online in any way relating to Arizona Biltmore Dentistry, doctors or employees will be the sole right and property of Sun Valley Ventures LLC DBA Arizona Biltmore Dentistry and the copyright of the content of the comment, rating, or review is hereby assigned to Sun Valley Ventures LLC DBA Arizona Biltmore Dentistry to utilize at our discretion in order to protect the practice and our patient's anonymity and privacy. **Initials__________**

Payment: Payment in full is required at the time of service. For your convenience, we accept cash, checks, debit, and credit cards, including Visa, MasterCard and Discover. Our office also offers No Interest and Extended Payment Plans, upon approved credit, through CareCredit. **Initials__________**

Estimates: Before treatment, we will perform a diagnosis and provide you with an estimate of the charges involved. As treatment progresses, it is possible that additional circumstances not be apparent at the initial exam, may be encountered. In this event, we will discuss options with you and proceed as necessary. **Initials__________**

Aged Account: The total balance on your account, after claim settlement, is due upon receipt of statement. Failure to keep this account current may result in Arizona Biltmore Dentistry being unable to provide additional dental services. In the event of a default, I agree that any information collected can be used to collect on my account, and I agree to pay all costs incurred in the attempt to collect on this account, including late fees of 10% or $30 (whichever is greater), finance charges, service and/or collection agency fees, attorney's fees and court costs. **Initials_________**

Appointments: If you are unable to keep a scheduled appointment, we ask that you provide us with 48 hour notice as a courtesy. **Notice of less than 24 hours may result in a minimum charge of $50.00**. We understand emergencies arise; we are sensitive to those events.
Initials________

Assignment of Benefit: I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my dental claims. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Arizona Biltmore Dentistry.

Signature of Person Responsible for Account

____ ______________________________

Printed Name of Person Responsible for Account **Date**

Arizona Biltmore Dentistry
Notice of Privacy Practices

How your Health Information may be used…

…To Provide Treatment

We will use your PHI inside our office to provide you with the best dental care possible! This may include office and clerical procedures used to streamline coordination between the Doctor, his Assistants, Hygienists, and business office staff. In addition, your treatment may require us to share your PHI with other entities such as referring Doctors, Clinical Laboratories, or your pharmacy.

…To Obtain Payment

We may include your PHI with paperwork sent to collect payment for the services you receive in our office, such as with insurance forms sent either through the mail or electronically. We will be sure to only work with companies with a similar commitment to the protection of your PHI.

…To Conduct Dental Care Operations

Your PHI may be used during performance reviews or training of our staff. It is possible your PHI would be disclosed during audits by insurance companies or government agencies as a part of their quality assurance or compliance reviews. Your PHI may be reviewed in the process of certification, licensing, or credentialing.

…In Patient Reminders

Because we believe regular care is very important to your dental health, we will remind you of an appointment you've scheduled or that it is time to contact us and make an appointment. Additionally, we may contact you to follow up on your treatment or to inform you of treatment options that may be available for you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best possible preventative, restorative, and cosmetic treatment modern dentistry can provide. This may include postcards, folding postcards, letters, voicemail messages, and electronic reminders such as e-mail (unless you tell us that you do not want to receive these reminders).

…Abuse or Neglect

We will notify the proper government agency if we believe a patient is the victim of abuse, neglect, or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we are specifically required or authorized by law or with the patient's agreement.

...Public Health or National Security

We may be required to disclose PHI to federal officials or military authorities when it is necessary to complete an investigation related to public health or national security.

…For Law Enforcement

We may be required to disclose PHI to a law enforcement official for law enforcement purposes. An example would be if you are a victim of a crime or in order to report a crime.

…Family, Friends, and Caregivers

With your permission, we may share your PHI with those you tell us will be helping you with your home hygiene, treatment, medication, or payment. If there is an emergency, and you are unable to tell us what you want, we will use our very best judgment in sharing your PHI, and only when it will be important to those participating in providing your care.

…To Coroners, Funeral Directors, and Medical Examiners

We may be required by law to provide PHI to coroners, funeral directors, or medical examiners in order to determine a cause of death or prepare for a funeral.

…Research

Advances in dental knowledge often involve learning from the careful study of the dental histories of prior patients. Formal review of dental histories as a part of a research study will happen only under the ethical guidance of an Institutional Review Board.

Your Rights as a Patient

You have the right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. You have the right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations. You have the right to inspect and copy your PHI. You have the right to amend your PHI. You have the right to receive an accounting of disclosures of PHI. You have the right to obtain a paper copy of this notice from us upon request.

Initials___________

ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

HIPAA- I acknowledge that I have received a copy of the Arizona Biltmore Dentistry Notice of Privacy Practices, containing a complete description of the uses and disclosures of my health information. This is simply an acknowledgement of receipt and nothing more.

Patient Name____
Signature_____________________________________Date_________________________

APPOINTMENTS AND FINANCIAL POLICY. I acknowledge that I have received a copy of Arizona Biltmore Dentistry Appointments and Financial Policy. I have read, understand and agree to the policy.

Signature of Responsible Party_______________________________Date______________

ASSIGNMENT OF BENEFIT. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or the dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to use your disclosure of my protected health information to carry out payments activities in connection with my dental claims. **I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Arizona Biltmore Dentistry.**

Signature of Responsible Party_____________________________Date_______________

Please fax or email 48 hours prior to your appointment