



Welcome!

Thank you for choosing us for your dental needs. Please complete the following information so we can best serve you.

PATIENT INFORMATION

Name: Last First MI Today's Date: / /

Nickname/preferred name: Male Female Birthdate: / /

Home Address: Street Apt #

City State Zip Code

Phone: Home # ( ) Work # ( ) Cell # ( )

Email: Preferred contact method:

Employer: Occupation:

Employer's Address: Street Ste #

City State Zip Code

When/where is the best time to reach you?

How did you hear about our office? (Please list name, if applicable)

Other family members seen by us:

Previous dentist and location: Date of last exam:

SPOUSE INFORMATION

His/Her name: Employer:

Work #: Birthdate: / /

INSURANCE INFORMATION

Primary

Insurance Co. Name: Group, Plan or Policy #:

Insured's Name: Relationship to Patient:

Insured's Birthdate: Insured's SS #:

Insured's Employer:

**Secondary**

Insurance Co. Name: \_\_\_\_\_ Group, Plan or Policy #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Insured's Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Insured's SS #: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Unless other arrangements have been made, payment is due in full at time of treatment. I understand that I am responsible for payment of services provided at this office, including any co-payment and deductibles that my insurance does not cover. I understand that information provided by this office regarding insurance reimbursement is an estimate only and that I am responsible for all costs of dental treatment. I hereby authorize the release of pertinent information, including diagnosis and records of treatment or examination, to my insurance company.

**HEALTH INFORMATION**



**MEDICAL HISTORY**

Do you have a personal physician?  Yes  No Date of last visit: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Are you currently under the care of a physician or specialist for a specific medical condition?  Yes  No

If yes, please explain: \_\_\_\_\_

Do you smoke or use other forms of tobacco?  Yes  No

If yes, approximately how much and for how long? \_\_\_\_\_

Are you taking any prescription / over-the-counter medications?  Yes  No

If yes, please list each one and the dosage: \_\_\_\_\_

**For Women:** Are you pregnant?  Yes (Week #\_\_\_\_)  No Are you nursing?  Yes  No

**Have you ever had any of the following? Please mark all that apply:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Abnormal bleeding/<br>hemophilia | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Liver disease       |
| <input type="checkbox"/> HIV/AIDS                         | <input type="checkbox"/> Difficulty breathing      | <input type="checkbox"/> Pacemaker           |
| <input type="checkbox"/> Anemia                           | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Radiation treatment |
| <input type="checkbox"/> Arthritis                        | <input type="checkbox"/> Epilepsy                  | <input type="checkbox"/> Rheumatic fever     |
| <input type="checkbox"/> Artificial heart valves          | <input type="checkbox"/> Dizziness/fainting spells | <input type="checkbox"/> Seizures            |
| <input type="checkbox"/> Artificial joints                | <input type="checkbox"/> GERD                      | <input type="checkbox"/> Sinus problems      |
| <input type="checkbox"/> Asthma                           | <input type="checkbox"/> Glaucoma                  | <input type="checkbox"/> Stroke/TIA          |
| <input type="checkbox"/> Cancer                           | <input type="checkbox"/> Heart disease             | <input type="checkbox"/> Thyroid problems    |
| <input type="checkbox"/> Cold sores                       | <input type="checkbox"/> Heart attack              | <input type="checkbox"/> Tuberculosis        |
| <input type="checkbox"/> Colitis                          | <input type="checkbox"/> Hepatitis                 | <input type="checkbox"/> Ulcers              |
| <input type="checkbox"/> Congenital heart defect          | <input type="checkbox"/> High blood pressure       | <input type="checkbox"/> VD (Type_____)      |
|   | <input type="checkbox"/> Kidney disease            | <input type="checkbox"/> Other_____          |

Comments/details: \_\_\_\_\_

**Are you allergic or had a negative reaction to any of the following?**

- |   |                                       |  |
|---|---------------------------------------|--|
| <input type="checkbox"/> Aspirin            | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Sulfa Drugs       |
| <input type="checkbox"/> Codeine            | <input type="checkbox"/> Latex        | <input type="checkbox"/> Other             |
| <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Penicillin   | <input type="checkbox"/> None of the Above |

Please provide details of the type of allergy or reaction, as well as any other allergies not listed:

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**DENTAL INFORMATION**

What is your **primary purpose** in coming to the dentist today? \_\_\_\_\_

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Do you require **antibiotics** before dental treatment?  Yes  No

Have you had difficulty associated with prior dental treatment?  Yes  No

If so, please explain: \_\_\_\_\_

Do you **floss** regularly?  Yes (# of times per week \_\_\_\_\_)  No

Do you use an **electric toothbrush**?  Yes  No      Do you use a **water pik**?  Yes  No

Do you use any **mouth rinses**?  Yes (Type and frequency: \_\_\_\_\_)  No

Have you ever had **periodontal disease**?  Yes  No      Gum surgery/**deep cleaning**?  Yes  No

Do you frequently have a **dry mouth**?  Yes  No

Difficulty swallowing or strong **gag reflex**?  Yes  No

Do you now or have you ever experienced pain/discomfort in your jaw joint (**TMJ**)?  Yes  No

Are your teeth **sensitive** to hot, cold, sweets, etc?  Yes (Please explain: \_\_\_\_\_)  No

Have you ever had **orthodontic** treatment (braces)?  Yes (How long ago? \_\_\_\_\_)  No

Are you interested in **teeth whitening**?  Yes  No

Is there anything else regarding your teeth or overall oral health that you would like to discuss?

If so, please explain: \_\_\_\_\_

The information I have provided is correct to the best of my knowledge. I understand that the information I provided will be held in the strictest confidence and in accordance with current HIPAA guidelines. I also understand that I am responsible to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**FOR OFFICE USE**

Doctor's Comments: \_\_\_\_\_

Initials: \_\_\_\_\_ Date: \_\_\_\_\_



## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

### SECTION A: PATIENT GIVING CONSENT

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ DOB: \_\_\_\_\_

### SECTION B: 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 disclosures 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 maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

**Contact Person: Amber Kerr**

**Telephone: (520) 297-2514 Fax: (520) 297-4627**

**E-mail: innovationdentalov@gmail.com**

**Address: 1830 E Innovation Park Dr, Oro Valley, AZ 85755**

**Right to Revoke:** You will 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 this 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.

### SIGNATURE SECTION

I (please print), \_\_\_\_\_, have had full opportunity to read and consider the contents of this 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 treatment, payment activities and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

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

**HIPAA Form 1**

### REVOCAION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## GENERAL CONSENT FOR DENTAL TREATMENT

Thank you for choosing Innovation Dental for your oral health needs! We look forward to providing the best dental care possible for you and your family.

As with all areas of medicine, there are some associated risks with dental treatment. While these complications are rare, they can and do occur. We are required to inform you of some of these associated risks and obtain your written consent for proposed treatment at our dental office.

These risks and complications include, but are not limited to the following:

1. Pain, swelling, and discomfort after treatment.
2. Infection in need of medication, a follow-up procedure, or other treatment.
3. Temporary, or on rare occasion, permanent numbness, pain, tingling or altered sensation of the lip, face, chin, gums, and tongue along with possible loss of taste.
4. Swallowing or inhaling small objects.
5. Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist.
6. Allergic reaction to medications or materials used during dental procedures and treatment.

We work hard to ensure that every patient is satisfied with the care they receive, however, we cannot guarantee the success of any treatment. It is important that you follow the doctor and staff's advice and recommendations regarding medication, pre- and post- treatment instructions, referrals to specialists, and the need to return for future appointments to ensure the best treatment outcome possible.

We know that your time is valuable. We will do our best to see you in a timely manner for each appointment. In return, we ask that you arrive 5-10 minutes early for your scheduled visits. If you are more than 15 minutes late we may ask that you reschedule for a later time. In addition, we require at least **2 working days notice** if you are unable to keep an appointment. Patients who fail to do so may be charged a reasonable fee for the missed appointment.

We intend to provide every patient with quality treatment in a professional and friendly environment. Please let us know if there is anything we can do to improve your experience at our dental office.

By signing below you signify that you have read and understand the information provided, and that you have had any questions answered to your satisfaction. Thank you!

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature (Guardian if patient is a minor)



### INFORMATION ABOUT OUR DENTAL INSURANCE POLICY

To ensure your experience at our office is as smooth as possible, we find it is helpful to explain some information about dental insurance. Please feel free to ask if you any questions about the information below.

- Our computer system will estimate your deductible and the amount covered on dental procedures. Please remember that this is only an estimate based on our history with your insurance company. If your insurance covers less than expected, you will be responsible for the balance. If they should cover more, a credit will be applied to your account or a prompt refund will be mailed, depending on your preference.
- Some insurance companies limit the procedures they will cover. Please be assured that we will always recommend the treatment that is appropriate for your health, not what is dictated by your insurance company.
- Dental insurance is a contract between you, the insurance carrier, and, if applicable, your employer. Although we are not a party to that contract, we will make every effort to provide the appropriate information to expedite a claim to the insurance company. Ultimately, any uncovered procedure is the patient's responsibility.
- Please let us know when there are changes in your employment or insurance coverage that might affect your benefits.
- If you have two insurance carriers, please let us know so that we may provide you with the necessary documentation to file for your secondary coverage. Because of the time and complication involved, we are unable to provide that service for you. We ask that you pay the estimated portion of your treatment at the time of service based on your primary insurance. Then, after you file the proper forms, you will be reimbursed directly by the secondary insurance company.

Thank you for reviewing our insurance policy. We want this process to be as smooth as possible so that we can focus on your oral health.

I understand and accept the information above.

Initial \_\_\_\_\_ Date \_\_\_\_\_