PHOENIX
COMPREHENSIVE DENTISTRY

Patient Information

Patient Name:_____ Preferred Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Cell Phone:_____ Home Phone:_____

Email:_____ ☐Married ☐Single ☐Child

Gender:_____ Age:_____ Date of Birth:_____ Social Security #:_____

Employer:_____ Occupation:_____

Work Address:_____ Work Phone:_____

Emergency Contact:_____ Phone:_____

Parent / Guardian Information (If under the age of 18)

Parent/Guardian Name:_____ Relationship to child:_____

Address:_____ City:_____ State:_____ Zip:_____

Cell Phone:_____ Home Phone:_____

Gender:_____ Age:_____ Date of Birth:_____ Social Security #:_____

Employer:_____ Occupation:_____

Work Address:_____ Work Phone:_____

Insurance Information

Primary Insured (Subscriber):_____ Relationship to Patient:_____

Date of Birth:_____ Subscriber ID#:_____

Subscriber Employer or Plan Sponsor:_____ Group#:_____

Insurance Company:_____

Additional Insurance

Primary Insured (Subscriber):_____ Relationship to Patient:_____

Date of Birth:_____ Subscriber ID#:_____

Subscriber Employer or Plan Sponsor:_____ Group#:_____

Insurance Company:_____

Authorization and Release

I authorize my insurance company to pay Smile Today all insurance benefits otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges not paid by insurance.** Smile Today may use my health care information and may disclose such information to my insurance company (ies) and their agents for the purpose of obtaining payment for the services and determining insurance benefits payable for related services, as pertaining to the HIPAA guidelines.

_____

Patient/Parent or Guardian Signature Printed Name Date

Dental History

Reason for today's visit: _____

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

Approx date of last dental visit: _____

Please mark all that apply:

- ☐ TOOTHACHE
- ☐ LOOSE, CHIPPED, CRACKED OR BROKEN FILLINGS
- ☐ LOOSE, CHIPPED, CRACKED OR BROKEN TEETH
- ☐ FOOD CATCHES
- ☐ FLOSSING BREAKS OR HURTS
- ☐ PAIN, CLICKING OR POPPING OF JAW
- ☐ GRINDING OF TEETH
- ☐ CLENCHING OF JAW
- ☐ HEAD ACHES
- ☐ SNORING / SLEEP APNEA
- ☐ SENSITIVITY
  - ☐ COLD
  - ☐ HOT
  - ☐ SWEET
  - ☐ CHEWING
  - ☐ TOUCH
- ☐ SINUS PROBLEM
- ☐ GAGGING
- ☐ DRY MOUTH
- ☐ DARK OR WHITE SPOTS ON TEETH
- ☐ GUMS
  - ☐ BLEEDING
  - ☐ TENDER OR SORE
- ☐ LOOSE TEETH
- ☐ TEETH HAVE SHIFTED
- ☐ BAD BREATH
- ☐ BAD TASTE IN MOUTH
- ☐ SORES OR GROWTHS IN MOUTH
- ☐ OTHER _____

Medical History

Please mark all that apply:

Have you been: ☐ Hospitalized? ☐ Do You Have Allergies?

Please describe: _____

YES	NO	
☐	☐	*PRE-MED - AMOX
☐	☐	*PRE-MED-CLIND
☐	☐	*PRE-MED-OTHER _____
☐	☐	ALLERGY - ASPIRIN
☐	☐	ALLERGY - CODEINE
☐	☐	ALLERGY - ERYTHRO
☐	☐	ALLERGY - HAY FEVER
☐	☐	ALLERGY - LATEX
☐	☐	ALLERGY - PENICILLIN
☐	☐	ALLERGY - SULFA
☐	☐	ALLERGY - OTHER _____
☐	☐	ANEMIA
☐	☐	ARTHRITIS
☐	☐	ARTIFICIAL HEART VALVE
☐	☐	ARTIFICIAL JOINTS
☐	☐	ASTHMA
☐	☐	BACK PROBLEMS

YES	NO	
☐	☐	BIPHOSPHATE MEDS (FosaMax, Acetol, Atelviz, Didronel, Boniva)
☐	☐	BLEEDING DISORDERS
☐	☐	BLOOD THINNERS
☐	☐	BLOOD DISEASE
☐	☐	BLOOD TRANSFUSION
☐	☐	CANCER _____
☐	☐	CHEMICAL / DRUG DEPENDENCIES
☐	☐	CHEMO THERAPY
☐	☐	CIRCULATORY PROBLEMS
☐	☐	CORTISONE TREATMENT
☐	☐	DIABETES
☐	☐	DIZZINESS
☐	☐	EPILEPSY
☐	☐	FAINTING
☐	☐	GLAUCOMA
☐	☐	HEAD INJURIES

YES	NO	
☐	☐	HEART DISEASE
☐	☐	HEART MURMUR
☐	☐	HEART PROBLEMS
☐	☐	HEMOPHILIA
☐	☐	HEPATITIS
☐	☐	HIGH BLOOD PRESSURE
☐	☐	HIV
☐	☐	JAUNDICE
☐	☐	KIDNEY DISEASE
☐	☐	LIVER DISEASE
☐	☐	MARIJUANA USAGE
☐	☐	MENTAL DISORDERS
☐	☐	MITRAL VALVE PROLAP
☐	☐	NERVOUS DISORDERS
☐	☐	NURSING
☐	☐	PACEMAKER
☐	☐	PERSISTENT COUGH

YES	NO	
☐	☐	PREGNANT
☐	☐	RADIATION TREATMENT
☐	☐	RESPIRATORY PROBLEMS
☐	☐	RHEUMATIC FEVER
☐	☐	SCARLET FEVER
☐	☐	SHORTNESS OF BREATH
☐	☐	STROKE
☐	☐	SWELLING FEET / ANKLE
☐	☐	TAKING BIRTH CONTROL
☐	☐	THYROID CONDITION
☐	☐	TOBACCO USAGE
☐	☐	TONSILLITIS
☐	☐	TUBERCULOSIS
☐	☐	ULCERS
☐	☐	VENEREAL DISEASE
☐	☐	OTHER _____

Please list the medications you are currently taking

(including over the counter, supplements, and herbals)

Name	Dosage	Medical Condition

Physicians Name: _____ Phone: _____

Pharmacy Name: _____ Phone: _____

In Office Use

HEAD & NECK EXAM	WNL or : _____
SOFT TISSUE	WNL or : _____
TMJ EXAM	WNL or : _____
OCCLUSION	CLASS I II II
ORTHO	☐ YES ☐ NO

In Office Notes

BP:

PULSE:

To the best of my knowledge the above information is accurate and complete. I will not hold the doctor or any members of their staff responsible for any errors or omissions I may have made in the completion of this form.

PATIENT / GUARDIAN SIGNATURE | PRINTED NAME | DATE

DR.'S SIGNATURE | DATE

PHOENIX
COMPREHENSIVE DENTISTRY

NOTICE OF PRIVACY PRACTICES

PROTECTING YOUR CONFIDENTIAL HEALTH INFORMATION IS IMPORTANT TO US!

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.

OUR PROMISE!

Dear Patient:
This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we are taking the new Federal (HIPAA – Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office

SO WHAT HAS CHANGED? WHY A PRIVACY POLICY NOW? VERY GOOD QUESTIONS!

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare.

The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your **HEALTH INFORMATION** only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

HOW YOUR HEALTH INFORMATION MAY BE USED

TO PROVIDE TREATMENT

We will use your HEALTH INFORMATION within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing you services and/or treatment.

TO OBTAIN PAYMENT

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

TO CONDUCT HEALTH CARE OPERATIONS

Your health information may be used during performance evaluation of our staff. Some of our best teaching opportunities use clinical situation experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process and certification, licensing or credentialing activities.

IN PATIENT REMINDERS

Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to 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 preventive and restorative care modern dentistry can provide. They may include postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

ABUSE OR NEGLECT

We will notify government authorities 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 believe we are specifically required or authorized by law or with the patient's agreement.

PUBLIC HEALTH AND NATIONAL SECURITY
We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

FOR LAW ENFORCEMENT
As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

FAMILY, FRIENDS AND CAREGIVERS
We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medication, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION
Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

PATIENT ACKNOWLEDGMENT

PATIENT NAME:_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by your signature. We look forward to guiding you with your dental care.

PATIENT RIGHTS
This new law is careful to describe that you have the following rights related to your health information.

RESTRICTIONS
You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our clients.

CONFIDENTIAL COMMUNICATIONS
You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

INSPECT AND COPY YOUR HEALTH INFORMATION
You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

AMEND YOUR HEALTH INFORMATION
You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

DOCUMENTATION OF HEALTH INFORMATION
You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

REQUEST A PAPER COPY OF THE NOTICE
You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

ADDITIONAL PEOPLE WE CAN RELEASE INFORMATION TO:

_____

_____

_____

Patient/Parent or Guardian Signature | Printed Name | Date

PCD Missed Appointment Policy

Our goal is to provide quality individualized dental care in a timely manner. No-shows, late shows and cancellations inconvenience those individuals who need access to dental care. We would like to remind you of our policy regarding missed appointments.

Cancellation of an Appointment

In order to be respectful of the dental needs of other patients, please be courteous and call Dr. Monterosso's office promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 48 hours in advance, 2 buisness days. Appointments are in high demand, and your early cancellation will allow another patient access to timely dental care.

How to Cancel Your Appointment

To cancel your appointment, please call (602)-861-1245 during office hours and speak with the Office Coordinator at least 2 business days prior to appointment.

Late Cancellations: A cancellation is considered to be late when the appointment is cancelled without a 48 hour, 2 business days, advance notice please.

No Show Policy: A "no-show", is a patient who misses an appointment without cancelling it. A failure to be present at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show". This includes arriving 15 minutes after your scheduled appointment.

The missed appointment fees are not covered by insurance and will be the patient's responsibility. The first time there is a "no-show" or late cancellation, there will be one warning and no charge to the patient. A 2nd occurrence will result in a fee of $100 and must be paid prior to future office visits. Other re-occurrences will be charged $100 and the patient may be considered for discharge from the practice.

Patient Signature _____ Date _____