



Getting to Know You.....

Welcome to North Valley Comprehensive Aesthetic Dentistry-we're glad you've chosen to be our patient!

Let's get acquainted.....

Hobbies & Interests _____

Family? Kids? (Ages) _____

Business/Occupation _____

Reason(s) for today's visit _____

Today's dentistry allows us to enhance your smile quickly and easily. How would you like your smile to look? (Check boxes that apply)

- Straighter
- Whiter
- Shorter
- Longer
- Wider
- More Even
- Close Spaces
- Replace Silver Filings
- Replace Missing or Cracked Teeth
- Replace Partials/Dentures
- Fresher Breath
- Do your gums bleed upon Brushing? Yes No Upon Flossing? Yes No
- Have you been diagnosed with gum disease? Yes No
- Other Reason(s) for today's visit

Please explain _____

When would you like to begin? _____

Are you preparing for a special occasion? Wedding? Reunion? Vacation? When?

What concern do you want to start with first? _____

Thank you for letting us get to know you!!!

North Valley Family Dentistry

We would like to get to know you better!

Date _____

Patient Name _____ Male Female Single Married Other

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Employer _____ Work Phone _____

Social Security Number _____ Date of Birth _____ Referred by _____

For Insurance Purposes:

Name of Insurance Carrier _____ Group Number _____

Phone Number _____

Name of Cardholder _____ Cardholder's Date of Birth _____

Cardholder's Social Security Number _____ Cardholder's Employer _____

Dental History

In the last several months

have you experienced any of the following:

Sensitivity to:

Heat? Yes No

Cold? Yes No

Sweets? Yes No

Biting? Yes No

Food Impaction? Yes No

Bleeding, sore gums? Yes No

Unpleasant taste or odor? Yes No

Loose teeth/broken fillings? Yes No

Clicking of the jaw? Yes No

Pain (joints,ear,face)? Yes No

Difficulty opening or closing? Yes No

Difficulty chewing? Yes No

Grinding or clenching? Yes No

Bleeding, swollen/irritated gums? Yes No

Loose, tipped or shifting teeth? Yes No

Bad breath? Yes No

Have you ever had a reaction to a local anesthetic? Yes No

Are you dissatisfied with your teeth and their appearance? Yes No

Do you get frustrated b/c you always have something to be treated when you visit the dentist? Yes No

Have you ever had teeth removed? Yes No

How long have these teeth been missing? _____

Do you have any dental fears? Yes No

Are you concerned about the finances required to return your teeth to excellent dental health? Yes No

What is your present dental problem? _____

Do you have/had any of the following?

-Dentures Yes No

-Partial Dentures Yes No

-Braces Yes No

-Periodontal treatments Yes No

Please share the following dates:

-Your last cleaning _____/_____/_____

-Your last oral cancer screen _____/_____/_____

-Your last complete x-rays _____/_____/_____

Name of Previous Dentist _____

City _____ **State** _____

Phone Number _____

If you could whiten your teeth for a cost anyone could afford, would you do it? _____

Do you use chewing tobacco? Yes No

Do you smoke? Yes No

How much? _____ For how long? _____

If I could change my smile, I would:

-Make them brighter

-Make them straighter

-Close spaces

-Replace black metal fillings

with tooth-colored fillings

-Repair chipped teeth

-Replace missing teeth

-Replace missing crowns

that don't match

-Have a smile makeover

On a scale of 1-10, with 10 being the highest rating:

-How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

-Where would you rate your dental health now?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

Health History

Do you have any general health problems? Yes No

If so, please specify _____

Are you currently under a physician's care? Yes No

Reason _____

Any medications? _____

Have you had surgery? Yes No

If so, please specify _____

To the best of your knowledge, are you, or have you ever been
Afflicted with

Sinus problems Yes No

Headaches Yes No

Stroke Yes No

Dizziness/fainting Yes No

Epilepsy Yes No

Asthma Yes No

Persistent cough Yes No

Allergies Yes No

Material allergies (latex, metal, chemicals) Yes No

Food Allergies Yes No

Drug Allergies _____

Osteoporosis Yes No

Diabetes Yes No

Tobacco habit Yes No

Blood disease Yes No

Heart Problems Yes No

Artificial heart valve Yes No

Heart murmur Yes No

Mitral valve prolapse Yes No

High blood pressure Yes No

Pacemaker Yes No

Kidney problems Yes No

Liver disease Yes No

Arthritis, Rheumatism Yes No

Artificial joints Yes No

Hepatitis Yes No

AIDS/HIV Yes No

Stomach problems Yes No

Cancer Yes No

Chemotherapy Yes No

Radiation treatment Yes No

Pregnancy/Due Date _____ Yes No

Consent for Treatment

I understand the preceding medical history information is necessary to provide me with dental treatment in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, which may release such information to you. I will notify the doctor of any change in my health history or medication.

I hereby authorize the doctors, or designated staff, to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.

Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by the doctor, and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Photo consent: If any before/after photos are taken of dental work performed, I give the doctor permission to use photos for educational purposes and lecture presentations.

Financial Policy

1. **If you have dental insurance** that is currently of effect, we may begin treatment against anticipated insurance benefits.

Remember, insurance is a contract between you and your insurance carrier. Some insurance companies pay more and some pay less. **We will estimate your portion of payment, which will be due at the time of treatment. Any balance that is outstanding after 60 days is entirely your responsibility.**

2. **If you do not have dental insurance**, payment is due for services as they are rendered.

We accept all major credit cards as well as checks and cash. We do NOT extend credit. Instead, we suggest private financing. We also have financing available through Care Credit and ChaseHealthAdvance. Our financial Coordinator would be happy to give you more information on this option.

I understand the consent for treatment and the financial policy of this office regarding "If you have dental insurance"/ "If you do not have dental insurance." I further agree to pay all finance charges, collection cost, attorneys fees and any other cost that may be incurred to enforce collection of any amount outstanding. A late fee of \$25 will be added after a balance is past 90 days due. I agree to the terms of this financial policy. I will pay by:

Check _____ Cash _____ Credit Card _____ Other _____
(\$25 charge for returned checks)

Signature

Date

CANCELLATION / NO SHOW POLICY

In order to ensure that quality patient care is maintained and all patients can be accommodated it is important that you notify North Valley Family Dentistry with your intentions to cancel or change your appointment at least **twenty-four business hours (24)** prior to your reserved appointment by calling (623) 551-9200. If you have an appointment reserved on Monday, please call the office on the preceding Thursday (one business day) to cancel or change that appointment.

Please be aware there is a \$50 FEE for any appointment cancelled less than 24 hours in advance and for no shows. Our Dentist and Hygienist havset their time aside for especially for you.

A \$100 FEE will apply for 2+ hour appointments.

Please take the time and consideration needed to provide the proper notification of your intention to cancel your visit with your Provider.

We understand there may be times you will miss an appointment due to family emergency or obligations and we will take these situations into account, however, we strongly encourage you to inform us within 1 business day prior to your reserved appointment so that we can accommodate another patient in that time slot.

I, _____ have read and had the above policy explained to me. I agree to abide by the request to notify the practice at least one business day in advance of a reserved appointment of my intention to cancel or change my appointment. I understand this assessment will not be charged to my insurance carrier and I will be responsible for paying for it.

I also understand that with three (3) or more missed appointments, North Valley Family Dentistry has the right to discharge me from the practice. If discharged, North Valley Family Dentistry will notify me in writing regular mail.

I have read the above information, and I agree to these terms:

Signature of Patient or Responsible Party

Date

Printed Name of Patient

Relationship to Patient

Thank you for your time and cooperation on this matter.

**Sincerely,
North Valley Family Dentistry**

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 09-2007, 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._____ for each page, \$_____ 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 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: Jammie Shaughnessy

Telephone: 623-551-9200 Fax: 623-551-9102

E-mail: northvalleyfamilydentist@yahoo.com

Address: 42104 N Venture Court, blg E Anthem, AZ 85086

***North Valley Family Dentistry
HIPPA Privacy Policy
(Health Insurance Portability and Accountability Act)***

I have read the North Valley Family Dentistry HIPPA Privacy Policy and understand my rights to privacy.

Signature

Date

Signature of Parent or Guardian

Date