Welcome.

COUNTRYCLUB DENTAL
FLAGSTAFF

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

ABOUT YOU:

Today's Dote: _____ / _____ / _____

Name: _____
LAST FIRST MI MR. / MRS. / MS. / DR.

I prefer to be called: _____

Email Address: _____

Birthdate: _____ / _____ / _____ Age: _____

SS#: _____ ❍ Male ❍ Female

Home Address: _____
APT / SUITE

_____
CITY STATE ZIP

Hm: (_____) _____

Cell: (_____) _____

Wk: (_____) _____ Ext: _____

DL#: _____

❍ Single ❍ Married ❍ Divorced ❍ Widowed ❍ Separated

Employer: _____

Occupation: _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____

Last Visit Date: _____ / _____ / _____

INSURANCE INFORMATION:

Primary Insurance

Insurance Co. Name: _____

Address: _____

Phone#: (_____) _____

Group# : _____

Member ID# : _____

Insured's Name: _____ Relation: _____

Birthdate: _____ / _____ / _____

Employer: _____

Employer's Phone#: (_____) _____

Secondary Insurance

Insurance Co. Name: _____

Address: _____

Phone#: (_____) _____

Group# : _____

Member ID# : _____

Insured's Name: _____ Relation: _____

Birthdate: _____ / _____ / _____

Employer: _____

Employer's Phone#: (_____) _____

Emergency Contact

Name: _____ Relation: _____

Wk#: (_____) _____

Hm#: (_____) _____

Address: _____

_____

SPOUSE INFORMATION:

His / Her Name: _____

Contact: (_____) _____ Ext: _____

Birthdate: _____ / _____ / _____

Person Responsible for Account: _____

Relation: _____ Contact#: (_____) _____

Billing Address: _____

_____

SS #: _____ or DL#: _____

MEDICAL HISTORY:

Physician's Name: _____

Phone#: (_____) _____

Date of last visit: _____ / _____ / _____

Are you currently under the care of a physician? ❍ Yes ❍ No

Please explain: _____

Do you smoke or use tobacco in any other form? ❍ Yes ❍ No

Have you had any metal rods, pins or implants? ❍ Yes ❍ No

Are you taking any prescription / over-the-counter or herbal supplemental drugs? ❍ Yes ❍ No

Please list each one: _____

_____

Have you ever taken Fosamax, or any other bisphosphonate? ❍ Yes ❍ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ❍ Yes ❍ No

For Women:

Are you using any prescribed method of birth control? ❍ Yes ❍ No

Are you pregnant? ❍ Yes ❍ No Week#: _____

Are you nursing? ❍ Yes ❍ No

Have you ever had any of the following medical problems?

❒ Abnormal Bleeding
❒ Alcohol / Drug Abuse
❒ Anemia
❒ Arthritis
❒ Artificial Bones / Joints / Valves
❒ Asthma
❒ Blood Transfusion
❒ Cancer / Chemotherapy
❒ Colitis
❒ Congenital Heart Defect
❒ Diabetes
❒ Difficulty Breathing
❒ Emphysema
❒ Epilepsy
❒ Fainting Spells
❒ Frequent Headaches
❒ Glaucoma
❒ Hay Fever
❒ Heart Attack
❒ Heart Murmur
❒ Heart Surgery
❒ Hemophilia
❒ Hepatitis
❒ Herpes / Fever Blisters
❒ High Blood Pressure
❒ HIV+ / AIDS
❒ Hospitalized for Any Reason
❒ Kidney Problems
❒ Liver Disease
❒ Low Blood Pressure
❒ Lupus
❒ Mitro Valve Prolapse
❒ Osteoporosis / Pagel's Disease
❒ Pacemaker
❒ Psychiatric Treatment
❒ Radiation Treatment
❒ Rheumatic / Scarlet Fever
❒ Seizures
❒ Shingles
❒ Sickle Cell Disease / Traits
❒ Sinus Problems
❒ Stroke
❒ Thyroid Problems
❒ Tuberculoses (TB)
❒ Ulcers
❒ Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

❒ Aspirin
❒ Tetracycline
❒ Latex
❒ Penicillin
❒ Other
❒ Erythromycin
❒ Codeine
❒ Dental Anesthetics
❒ Tetracycline

Please list any other drugs / materials that you are allergic to:

_____

_____

DENTAL HISTORY:

Do you require antibiotics before dental treatment ❍ Yes ❍ No

Are you currently in pain? ❍ Yes ❍ No

Have you ever had a serious / difficult problem associated with any previous dental work? ❍ Yes ❍ No

Do you have fears about going to the dentist? ❍ Yes ❍ No

Have you ever had gum treatment? ❍ Yes ❍ No

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

Your current dental health is: ❍ Good ❍ Fair ❍ Poor

Do you like your smile? ❍ Yes ❍ No

Do your gums ever bleed? ❍ Yes ❍ No

How many times a week do you floss? _____ Brush? _____

Type of bristles? ❍ Soft ❍ Medium ❍ Hard

How long do you use a toothbrush before replacing it? _____

Are your teeth sensitive to heat, cold, or anything else? _____

Have you lost any teeth? ❍ Yes ❍ No

If yes, why? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform his office of any changes in my medical status. I authorize dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____
Signature Date

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I om responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental enrollment.
I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____
Signature Date

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

FOR OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient Named herein.

Initials: _____ Date: _____ / _____ / _____

MEDICAL HISTORY UPDATE:

I have read my medical history dated _____ / _____ / _____ and confirmed that it states past and present medical conditions.

_____
Signature Date

I have read my medical history dated _____ / _____ / _____ and confirmed that it states past and present medical conditions.

_____
Signature Date

COUNTRYCLUBDENTAL
FLAGSTAFF

CONTINENTAL PLAZA, SUITE C-4
5200 E CORTLAND BOULEVARD,
FLAGSTAFF, AZ 86004

P: 928.526.4314 F: 928.714.1475

CountryClubDentalFlagstaff.com

OFFICE POLICIES

Welcome

In order to serve you better, please note the following office policies:

ALL fees, insurance deductibles and/or co-payments are due at the time of service unless prior arrangements have been made with the office management. We offer to bill your insurance carrier for you as long as we have complete billing information and your signature on file. Therefore, your signature below acknowledges the following:

INITIAL Regardless of your insurance coverage, all fees are ultimately your responsibility. We attempt to provide for you accurate estimates of your insurance benefits; however, you are responsible for all treatment fees regardless of the accuracy of our estimates given to you.

INITIAL Please notify us if a full set of dental x-rays or a panoramic x-ray has been taken within the last 5 years. Most insurance companies will NOT pay for another set within that time frame. Copies of readable/diagnostic x-rays need to be obtained from a previous dental office pending your request.

INITIAL We provide composite (white) fillings on all adult teeth. Some insurance companies will only allow the silver benefit. It will be your responsibility for the difference if such an allowance is made.

A $30.00 fee is charged for all returned checks.

INITIAL Effective 7/1/15: Our C.P.A. firm has implemented a new policy on delinquent accounts. If an account is 90 days past due, with no payments having been made during that time, the account will immediately go into the collections process. If you are unable to pay the balance in full it is your responsibility to contact the office upon statement receipt to discuss payment options. Any collection and/or legal fees incurred will be your responsibility. Costs of collection include, without limitation, all fees charged by a collection agency, attorney fees, small claims court costs and any other costs incurred in the effort to collect your debt.

INITIAL We provide a courtesy call approximately 48 hours prior to your appointment. HOWEVER, this is a courtesy and you are responsible to keep or cancel your appointment whether or not you were contacted. Please cancel and/or change within 48 hours prior to the appointment. There will be a $50.00 per hour charge for all missed appointments without appropriate notice, respective to your situation.

Thank you very much!

SIGNATURE

DATE

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DENTAL INSURANCE / FINANCIAL ARRANGEMENT

Payment is due at the time services are rendered unless payment arrangements have been approved in advance by our management staff.

If you have dental insurance, we will do everything we can to help you receive your maximum allowable benefit. In order to achieve this goal, we need you to take the necessary steps to understand your insurance plan. There are numerous different providers, plans and groups available. The following are key points in regards to your insurance you must be clear on:

- Your insurance policy is a contract between you and the insurance company. We are not a party to that contract.
- Most insurance policies have a yearly deductible, understand what that amount is as that is your financial responsibility.
- Most insurance policies only pay a percentage of the cost of your treatment, you are responsible for the remaining balance on your account after insurance pays/denies their portion.
- Not all services are a covered benefit, be familiar with what these services are.
- As a courtesy for you, we will submit all claims to your insurance company. However, if for any reason the claim is unpaid, you are responsible for all the charges incurred.

Please ask us, your human resources (HR) department and/or your insurance company. We are here to help you in any way we can!

I, , am financially responsible for any and all charges on my account. I have read and I understand the above information.

SIGNATURE

DATE

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 April 14, 2003, and will remain in effect until were place 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.

For more information about our privacy practices, or to request a copy of our Notice, please contact us using the information listed on this website.

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 pickup 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,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. We may charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request an alternative format,we will charge a cost-based fee for providing your health information in that format.

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, but not before April 14, 2003. If you request this accounting more than once in a 12-monthperiod,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 website 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 at the address or phone number provided on this website.

If you are concerned that we may have violated your privacy rights, 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 on this website. 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 anyway if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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ACKNOWLEDGEMENT RECEIPT & NOTICE OF PRIVACY PRACTICE

You may refuse to sign this acknowledgement.

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

SIGNATURE DATE

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

_____ **Individual refused to sign**

_____**Communication barriers prohibited obtaining the acknowledgement**

_____**An emergency situation prevented us from obtaining acknowledgement**

_____**Other (please specify)**

EMAIL FORM