patient information

patient name _____ social security # _____-_____-_____
last first middle initial

address: _____ DOB: ____/____/_____

city: _____ state: _____ zip: _____ age: _____

email: _____ Sex: ☐ M ☐ F

marital status: _____

phone #'s: home: _____-_____-_____ work: _____-_____-_____ ext _____ cell: _____-_____-_____

occupation: _____ employer/school: _____ employer phone: _____-_____-_____

dentistry: how can we help you

Who can we thank for referring you? _____

What had you switch dentists? _____

Do you have any dental fear or anxiety? ☐ yes ☐ no

if yes, please explain: _____

Are you proud of your smile? ☐ yes ☐ no

is there anything that you would like to improve? _____

What is the most important aspect(s) of your dentist?

☐ gentle ☐ cost ☐ accurate price ☐ same day treatment ☐ warrantied work

☐ other _____

dental insurance

who is responsible for this patient financially? _____

insurance company: _____ group # _____

subscriber: _____ subscriber social security number: _____-_____-_____ subsc. DOB ___/___/___
if not above if not above

how is the patient related to the subscriber? _____

assignment and release

I certify that I, and/or my dependent(s) have insurance coverage with the above named insurance company and assign directly to Dr Christopher Ballew and/or inspired Dental DBA Coolidge Family Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr Ballew or his office staff may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when written documentation is given to the office.

_____ _____ ____/____/_____
print name signature of patient, parent/guardian date

dental history

reason for todays vist: _____

date of last dental visit (approx): ____/____/_____ date of last dental x-rays ____/____/_____

place a checkmark for any of the following that apply:

- ☐ bad breath
- ☐ use of tobacco
- ☐ food collection
- ☐ loose teeth
- ☐ periodontal tx
- ☐ bleeding gums
- ☐ cheek biting
- ☐ foreign objects
- ☐ mouth pain
- ☐ sores
- ☐ blisters on lips or mouth
- ☐ dry mouth
- ☐ grinding teeth
- ☐ orthodontic tx
- ☐ sensitivity to: ☐ cold ☐ hot ☐ sweets ☐ biting/pressure
- ☐ burning sensation on tongue
- ☐ fingernail biting
- ☐ swollen gums (or tender)
- ☐ jaw pain/clicking/tiredness

how often do you brush? _____ how often do you floss? _____

medical history

** have you ever taken any of the group of drugs collectively referred to as "fen-fen"? (phentermine, pondimin, fenfluramine, redux, dexfenfluramine) yes no

place a checkmark for any of the following that apply:

- ☐ AIDS/HIV
- ☐ hepititus Type_____
- ☐ artificial heart Valve
- ☐ artificial Joints
- ☐ asthma
- ☐ special diet
- ☐ blood disease
- ☐ cancer
- ☐ kidney disease
- ☐ chemotherapy
- ☐ tumor (head/neck)
- ☐ pacemaker
- ☐ psychiatric care
- ☐ emphysema
- ☐ epilepsy
- ☐ anemia
- ☐ glaucoma
- ☐ heart Murmer
- ☐ heart Problems
- ☐ herpes
- ☐ jaundice
- ☐ jaw pain
- ☐ tonsilitis
- ☐ liver disease
- ☐ cortisone tx
- ☐ venereal disease
- ☐ diabetes type: ____
- ☐ radiation tx
- ☐ respiratory Disease
- ☐ fainting or dizziness
- ☐ arthritis/rheumatism
- ☐ Sinus Trouble
- ☐ skin rash
- ☐ stroke
- ☐ swollen feet/ankles
- ☐ swollen neck glands
- ☐ circulatory problems
- ☐ kidney disease
- ☐ nervous problems
- ☐ mitral valve prolapse
- ☐ cough (persistent/bloody)
- ☐ weight loss(unexplained)
- ☐ rheumatic Fever
- ☐ scarlet Fever
- ☐ headaches
- ☐ shortness of breath
- ☐ back problems
- ☐ abnormal bleeding with extractions or surgery
- ☐ thyroid problems
- ☐ chemical dependency
- ☐ tuberculosis
- ☐ low blood pressure
- ☐ high blood pressure
- ☐ congenital heart lesions

women:

- ☐ pregnant
- ☐ taking birth control
- ☐ nursing

if any marked, please breifly explain _____

_____

allergies:
- ☐ asprin
- ☐ latex
- ☐ local anesthetic
- ☐ barbiturates (sleeping pills)
- ☐ penicillin
- ☐ codeine
- ☐ other _____
- ☐ sulfa
- ☐ iodine

Current medications: _____

_____

signature _____

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Pratices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date Signed _____

Print Patient Name _____

Signature _____

Relationship to Patient _____

Coolidge Family Dental
1427 North Arizona Boulevard
Coolidge, AZ 85128

Coolidge Family Dental
Financial Agreement

Thank you for choosing Coolidge Family Dental for your dental health needs. We do not want finances to be an issue for our patients. We understand that it is not always possible to pay your dental bill in full so, we would like to explain our financial options. Please choose the option that works best for you.

1. Payment is due at the time treatment is rendered. We accept Cash, Check, Master Card, Visa, Discover, and CareCredit.

2. Dental Insurance – As a courtesy to you we will complete your insurance form and submit it to the insurance company. Your estimated co-payment (the amount not covered by your insurance) for treatment is due at the time treatment is provided. If you fail to bring the required insurance information to your appointments we will ask that you pay the bill in full and be reimbursed from your insurance company with paperwork provided by our office.

Our office does not guarantee that your insurance company will pay for the treatment you receive from our practice. If your claim is denied or the treatment is down-coded and or alternative benefits given, you will be responsible for paying the full balance amount left on the account at that time. _____
(please initial)
Our office will not enter into a dispute with your insurance company over any claim, although we will provide the necessary documentation your insurance company requests to settle the claim.

If your insurance company has not made payment within 60 days of billing, the balance will become your responsibility. Insurance coverage is a contractual agreement between the insurance company and you or your employer. We have no control over this relationship.

3. Monthly payment options – If you need to make long-term payments we can offer financing with CareCredit which offers up to 12 months NO INTEREST financing as well as longer terms with low interest rates. You must qualify for this option. Please do not hesitate to ask us about this option. We may conveniently qualify you right here in the office today.

4. We can offer up to 6-month payment plan *with a credit card on file* depending on the amount of the procedure.

Statements – All patients with an outstanding balance will receive a statement each month. There is a charge of $5.00 on all accounts 60 days overdue. All accounts over 90 days will be subject to our collection agency.

Returned Checks – A fee of $25.00 will be charged for any returned checks.

Broken Appointments – Our practice may charge you $40.00 for appointments broken without proper 48 hour weekday notice. We understand that emergencies occur. However, we want to make the appointment available for other patient

Please initial (_____)

I assign directly to Coolidge Family Dental, all insurance benefits, if any, otherwise payable to me for services rendered. I authorize and release information and payment of my dental benefits directly to the practice. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dental practice may use my heath care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I have read and fully understand my financial options and obligations. I understand that in the event my account becomes delinquent I will be responsible for any collections, legal fees and any other charges incurred to collect this account. Additionally, by signing this form I authorize Coolidge Family Dental to process credit card transactions initiated by me either by mail or phone and I authorize my credit institution to pay. Thank you for giving us the opportunity to serve your dental needs. If you have any questions about this form please let us know.

_____ _____

Print Name of Patient or Responsible Party Date

_____

Signature of Patient or Responsible Party