

**PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION**

Date \_\_\_\_\_

Last Name \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_

Prefers to be called by \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ CELL Phone \_\_\_\_\_

Date Of Birth \_\_\_\_\_ Age \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

Social Security # \_\_\_\_\_

(If Student) Students Name \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

If your child's last name and/or address are not the same as yours, please let us know

E-mail Address: \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

Insurance Company \_\_\_\_\_

Insurance Address \_\_\_\_\_

Insurance Phone Number \_\_\_\_\_

Group Number \_\_\_\_\_

Employer Name \_\_\_\_\_

Insured's Name \_\_\_\_\_

Date Of Birth \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Insured's I.D. Number \_\_\_\_\_

Insured's Social Security No. \_\_\_\_\_

**ACCOUNT INFORMATION**

**PERSON FINANCIALLY RESPONSIBLE**

Name \_\_\_\_\_

Relationship To Patient \_\_\_\_\_ Social Security Number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

**YOU**

Name \_\_\_\_\_

Occupation \_\_\_\_\_

Employer's Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

**YOUR SPOUSE**

Name \_\_\_\_\_

Occupation \_\_\_\_\_

Employer's Name \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

**GETTING TO KNOW YOU**

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

You Were Referred To Us By \_\_\_\_\_

Your Former Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Person To Contact For Emergency \_\_\_\_\_

Phone Number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

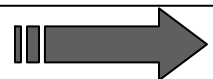
Closest Relative Not Living With You \_\_\_\_\_

Phone Number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

PLEASE TURN OVER AND SIGN



Patient Name

# DENTAL HISTORY

Patient Account Number

Medical Alert

**Welcome!** So that we may provide you with the best possible care,  
Please complete both sides of this medical/dental history form.  
All Information is completely confidential.

What is the reason for your visit today? \_\_\_\_\_

Date of Last Dental Visit \_\_\_\_\_ Last Dental Cleaning \_\_\_\_\_ Last Full Mouth X-rays \_\_\_\_\_

What was done at your last dental visit? \_\_\_\_\_

Previous Dentist's Name \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone \_\_\_\_\_

How often do you have dental examination? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

What other dental aids do you use? (Interplak, toothpick, etc.) \_\_\_\_\_

Do you have any dental problems now? Yes No

If yes, Please describe: \_\_\_\_\_

**Are any of your teeth sensitive to:**

Hot or cold? Yes No

Sweets? Yes No

Biting or Chewing? Yes No

Have you noticed any mouth odors or bad tastes? Yes No

Do you frequently get cold sores, blisters or  
any other oral lesions? Yes No

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease  
or tooth loss? Yes No

Have you noticed any loose teeth or change  
in your bite? Yes No

Does food tend to become caught in between  
your teeth? Yes No

If yes, where? \_\_\_\_\_

**Do you:**

Clench or grind your teeth while awake or asleep? Yes No

Bite your lips or cheeks regularly? Yes No

Hold foreign objects with your teeth?  
(pencils, pipe, pins, nails, fingernails) Yes No

Mouth breathe while awake or asleep? Yes No

Have tired jaws, especially in the morning? Yes No

Snore or have any other sleep disorders? Yes No

Smoke/chew tobacco or use other tobacco products? Yes No

**Have you ever had:**

Orthodontic treatment? Yes No

Oral Surgery? Yes No

Periodontal treatment? Yes No

Your teeth ground or the bite adjusted? Yes No

A bite plate or mouth guard? Yes No

A serious injury to the mouth or head? Yes No

If so, please describe, including cause \_\_\_\_\_

**Have you experienced:**

Clicking or popping of the jaw? Yes No

Pain? (joint, ear, side of face) Yes No

Difficulty in opening or closing the mouth? Yes No

Difficulty in chewing on either side of the mouth? Yes No

Headaches, neckaches or shoulder aches? Yes No

Sore muscles (neck, shoulders)? Yes No

**Are you satisfied with your teeth's appearance?** Yes No

Would you like to keep all of your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern?  
\_\_\_\_\_

Have you ever had an upsetting dental experience? Yes No

If yes, please describe \_\_\_\_\_

Is there anything else about having dental treatment that you would like us to know Yes No

If yes, please describe  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Name

Patient Account Number

**MEDICAL HISTORY**

Medical Alert

1. Have you been under the care of a medical doctor during the past two years? ..... Yes No  
 If yes, for what? \_\_\_\_\_  
 Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
2. Have you taken any medication or drugs during the past two years ..... Yes No
3. Are you taking any medication or drugs currently, including regular doses of aspirin or over the counter herbal medicines? ..... Yes No  
 If yes please list name and dosage.....
4. Have you ever taken any prescription drugs for weight loss, including Fen-Phen (fenfluramine-phentermine), Pondimin (fenfluramin), and Redux (dexfenfluramine)?..... Yes No
5. Are you aware of having an allergic (or adverse) reation to any medication or substance?..... Yes No  
 If yes, please list \_\_\_\_\_
6. Have you been a patient in the hospital during the past five years? .....Yes No
7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (surgery, Disease, Attack)....	Yes	No	Ulcers.....	Yes	No	Hepatitis A B C (circle)..	Yes	No
Chest Pain.....	Yes	No	Diabetes.....	Yes	No	Venerial Disease.....	Yes	No
Congenital Heart Disease.....	Yes	No	Thyroid Problems.....	Yes	No	A.I.D.S.....	Yes	No
Heart Murmur.....	Yes	No	Glaucoma.....	Yes	No	H.I.V. Positive.....	Yes	No
High Blood Pressure.....	Yes	No	Contact lenses.....	Yes	No	Cold Sores/Fever Blisters.	Yes	No
Mitral Valve Prolapse.....	Yes	No	Emphsema.....	Yes	No	Blood Transfusion.....	Yes	No
Artificial Heart Valve.....	Yes	No	Chronic Cough.....	Yes	No	Hemophilia.....	Yes	No
Heart Pacemaker.....	Yes	No	Tuberculosis.....	Yes	No	Sickle Cell Disease.....	Yes	No
Rheumatic Fever.....	Yes	No	Asthma.....	Yes	No	Bruise Easily.....	Yes	No
Arthritis/Rheumatism.....	Yes	No	Hay Fever.....	Yes	No	Liver Disease.....	Yes	No
Cortison Medicine.....	Yes	No	Latex Sensitivity.....	Yes	No	Yellow Jaundice.....	Yes	No
Swollen Ankles.....	Yes	No	Allergies or Hives.....	Yes	No	Neurological Disorders...	Yes	No
Stroke.....	Yes	No	Sinus Trouble.....	Yes	No	Epilepsy or Seizures.....	Yes	No
Diet (special/restricted).....	Yes	No	Radiation Therapy.....	Yes	No	Fainting or Dizzy Spells..	Yes	No
Artificial Joints (hip, knee, etc.).	Yes	No	Chemotherapy.....	Yes	No	Nervous/Anxious.....	Yes	No
Kidney Trouble.....	Yes	No	Tumors.....	Yes	No	Psychiatric/Psychological	Yes	No
8. Do you use more than two pillows to sleep?..... Yes No
9. Have you lost or gained more than 10 pounds in the past year?..... Yes No
10. Do you have or have you had any disease condition or problem not listed?..... Yes No  
 If yes, Please list: \_\_\_\_\_
11. **Women:** Are pregnant or think you may be pregnant? Yes \_\_\_\_\_ Months No Nursing? Yes No
12. **Women:** Do you use birth control medications? ..... Yes No

*I understand the above information is necessary to provide me with dental care 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, who my release such information to you. I will notify the dentist of any changes in my health or medications.*

Patient/Guardian Signature

Date

History Review

## **CONSENT FOR TREATMENT**

1. *I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) \_\_\_\_\_'s dental needs.*
2. *Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.*
3. *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.*
4. *I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.*

*Patient's Signature* \_\_\_\_\_ *Date* \_\_\_\_\_ *Witness* \_\_\_\_\_

*Parent/Responsible Party's Signature* \_\_\_\_\_ *Relationship to Patient* \_\_\_\_\_

## **FINANCIAL OPTIONS**

- 1) Cash discount save 5% if total paid in full at appointment.
- 2) 1/2 down first appointment 1/2 down second appointment. (Major treatment only)
- 3) Care Credit Line. (0% interest available)
- 4) Citibank (0% interest available)
- 5) Chase (0% interest available)
- 6) Dental Banc - Electronic funds transfer automatic check / savings deposited from account.
- 7) Dental Banc – Electronic funds transfer automatic from credit card

**Jeffrey D. Clark, DDS, PC**  
**8765 East Bell Road Suite 201, Scottsdale, AZ 85260**

**FINANCIAL POLICY**

**A) Prepay Courtesy (Pre-Payment of Treatment in Full):**

A prepayment bookkeeping courtesy of **5%** will be subtracted for treatment that exceeds \$100 of the total patient obligation if the patient pays in full at the first treatment visit. This courtesy requires that the patient **file and accept their own insurance**, and payment must be made by **cash, check or money order only**.

**B) Financing:**

For those patients wishing to extend payments over a longer period of time, various financing plans can be arranged in our office. These lines of credit are **up to 6 months, interest-free depending on the amounts**. There is **no prepayment penalty** and the process is simple and can usually be completed within 20 to 30 minutes.

**Forms of Payment:**

You may choose from any of the following (including any combination thereof) to pay in full or to pay your portion not paid by insurance or financing: Visa, MasterCard, American Express, Debit Card, Cash, Check, Money Order or the lines of credit referred to above.

**INSURANCE**

Our office understands the value of insurance benefits to our patients. We will gladly process and file your insurance at **no charge**. At the time of service, we will ask you only for your **estimated** portion. Please understand that this is only an **estimate**, and is based upon the information available to us. Benefits from most plans range between 50% and 80%. However, the insurance companies base the amount of benefit on a schedule of fees that are **arbitrarily** developed by the insurance companies. For this reason, we may receive a lower payment than the estimate we have given you.

The financial obligation for dental treatment is between you and our office. The insurance company is responsible to you, and not to our office. We will assist you in any way that we can, however, there are no guarantees and payment is due regardless of the benefits paid by your insurance.

**Once your carrier has paid the claim, any difference will be due upon receipt of our statement. If for any reason, we have not received your insurance carrier's payment 60 days after the claim, the remaining balance will be due and payable by you, and possibly subject to an 18% annual percentage rate interest charge.**

**In the event of default, legal interest on the indebtedness, collection cost (which could be as much as an additional 50%) and related attorneys' fees could also be added. In addition, a \$10.00 fee will be added for all returned checks.**

*Finally, please notify us at least 24 hours in advance if you cannot make your appointment. We have set aside a considerable amount of time for your appointment and would like to offer it to someone else if possible. If we receive less than 24 hours notice or you do not make your appointment at all there will be a \$50.00/hour charge on the second occurrence.*

I understand my financial options and obligations as described above. I am aware that 24 hours notice is required for any changes in scheduling. I am also aware that balances over 60 days will incur 18% APR finance charges. The treatment plan has been explained to me and I have agreed to the terms as listed.

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**Signature**

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**Date**

# Notice of Privacy Practices

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**Purpose:** This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

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# NOTICE OF PRIVACY PRACTICES

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**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.**

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## **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 \_\_\_\_\_, 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.

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## **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).

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## 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.

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## 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: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

Address: \_\_\_\_\_

Jeffrey D. Clark, DDS, FAGD, PC  
8765 East Bell Road, Suite 201  
Scottsdale, Arizona 85260

## Notice of Privacy Practices Patient Acknowledgement

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice, and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

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

Relationship to patient (if signed by a personal representative of patient) \_\_\_\_\_