****

PATIENT INFORMATION

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthday \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS# \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Sex M F Married \_\_\_\_ Widowed\_\_\_\_ Single\_\_\_\_ Divorced\_\_\_\_ Minor\_\_\_\_

**E-Mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Employer/School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer/School Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse or Parent Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person to contact in case of emergency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RESPONSIBLE PARTY

Name of person responsible for this account \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient \_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Driver’s License # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthday \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Currently a Patient in our office? Yes No E-Mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURANCE INFORMATION

Name of Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthday \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Employed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_

Insurance ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental History**

Reason for today’s visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of last Dental Care \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Former Dentist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last Dental X-Rays\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check if you have had any of the following:

\_\_\_\_\_Bad Breath \_\_\_\_\_Grinding teeth \_\_\_\_\_Sensitivity to hot \_\_\_\_\_ Sensitivity to Sweets \_\_\_\_\_Periodontal Treatment

\_\_\_\_\_Bleeding Gums \_\_\_\_\_Loose Teeth \_\_\_\_\_Sensitivity to cold \_\_\_\_\_ Sensitivity when biting \_\_\_\_\_Broken Fillings

\_\_\_\_\_Clicking or popping jaw \_\_\_\_\_Food Collection between the teeth \_\_\_\_\_Sores or growths in your mouth

How often do you floss? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How often do you brush? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

Physician’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of last visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as “Fen-Phen”? These include combinations of lonimin, Adipex, Fastin (brand names of Phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine) Yes No Have you ever used any Bisphosphonates? Yes No

Have you had any serious illnesses or operations? \_\_\_\_Yes \_\_\_\_No If Yes, describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a blood transfusion? \_\_\_\_Yes \_\_\_\_No If Yes, approximate date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Women: Are you pregnant? \_\_\_\_ Yes \_\_\_\_ No nursing? \_\_\_ \_ yes \_\_\_\_No taking Birth Control? \_\_\_\_Yes \_\_\_\_No

**Please circle if you have had any of the following: Check box if you DO NOT have any of the following** □

Anemia Congenital Heart Lesions Rheumatic Fever Scarlet Fever Arthritis, Rheumatism Hepatitis

Hernia Repair Cortisone Treatments Shortness of Breath Artificial Joints Cough, Persistent Hemophilia

Skin Rash High Blood Pressure Artificial Heart Valves Coughing up Blood Ulcer HIV/AIDS

Stroke Asthma Diabetes Jaw Pain Back Problems Heart Problems

Epilepsy Swelling of Feet or Ankles Kidney Disease Thyroid Problems Bleeding Abnormally Fainting

Liver Disease Tobacco Habit Blood Disease Glaucoma Mitral Valve Prolapse Cancer

Tonsillitis Headaches Pacemaker Tuberculosis Chemical Dependency Radiation Treatment

Heart Murmur Chemotherapy Respiratory Disease Venereal Disease Circulatory Problems Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List the medications you are currently taking and the correlating diagnosis Allergies**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization and Release**

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have changes in health. I certify that I and/or my dependant(s) have insurance coverage with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and have assigned directly to Dentistry at Greenway all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by the insurance or not. I authorize the use of my signature on all insurance submissions. The above named facility may use my health care information to the above named Insurance Companies 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 the current treatment plan is completed or one year from the dates signed below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient, Parent, Guardian, or Personal Representative Date

**Reviewed by Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT FINANCIAL RESPONSIBILITIES**

**Patient Financial Responsibility Policy Statement:**

Dentistry at Greenway is pleased to provide you, our patient, with the highest level of care for your health and quality of life. We strive to employ the most professional staff and deliver services to you with the latest technology and education available each day. You and Dentistry at Greenway, together, will combine our energies to bring positive results to your dental care needs. Dentistry at Greenway in its continuous efforts to deliver the best in care requires payment of all known patient responsible balances at time of service. These balances may include but are not limited to co-pays, deductibles or co-insurance (amounts as stated in the benefits coverage contract with your insurance carrier); any amounts due for patients who are "self-pay"; any amounts due from previous dates of service, or amounts that may be incurred during your current visit. We understand that circumstances may preclude you from paying amounts due at time of service.

­­­­­\_\_\_\_\_\_\_\_\_ (Initials)

**Payment Policy:** Payment is expected at time of service for any applicable co-pay, co-insurance, and/or deductible. Dentistry at Greenway accepts cash, checks, Visa, MasterCard, or American Express as forms of payment for your convenience. Failure to pay at time of service may result in re-scheduling of your appointment.

­­­\_\_\_\_\_\_\_\_\_ (Initials)

**Insurance Policy:** We will require a digital scan of your insurance card and driver's license at the time of your arrival. Dentistry at Greenway will bill your insurance company as a courtesy to you, but this billing service does not preclude your financial responsibility for the services received. Any deductible, co-insurance or non-covered services, including ineligibility are your responsibility. If Dentistry at Greenway is not contracted with your insurance provider, Dentistry at Greenway, as a courtesy, will submit claims to your carrier; any deductible, co-insurance or non-covered services, including ineligibility are your responsibility. Dentistry at Greenway will mail monthly statements and contact you to collect any open balances. Please inform our staff immediately of any insurance changes.

\_\_\_\_\_\_\_\_\_ (Initials)

**Non-Covered Service Policy:** Certain services performed by our office, for your benefit, are NOT COVERED by your insurance plan(s). Dentistry at Greenway suggests you contact your insurance carrier to verify your benefits and understand any non-covered services, as these will be your financial responsibility. Payment will be required prior to your appointment.

\_\_\_\_\_\_\_\_\_ (Initials)

**Late Arrivals:** In order for our dentists to see their patients in a timely manner, your help in arriving promptly for your appointment is required. If you are more than 10 minutes late, our office will reschedule your appointment to a new date and time. Tardiness affects your patient care as well as those patients that have a scheduled time after you. We understand your time is valuable and will do our best to respect your time and see you as promptly as possible. Please be aware that sometimes certain situations and emergencies can occur and cause your provider to run late. Please be patient in these circumstances.

**\_\_\_\_\_\_\_\_\_ (Initials)**

**Appointment Cancellations/No Shows/Reschedules:** There is a fifty dollar ($50.00) charge if you reschedule or no show for an appointment without giving 24 hours notice. These appointment times could have been given to another patient who needs dental care. We understand unusual circumstances can occur, at which time we ask that you please contact our office as soon as possible.

**\_\_\_\_\_\_\_\_\_ (Initials)**

**Returned Checks:** Our office charges a thirty-five dollar ($35.00) fee for all accounts closed, stop payment or non-sufficient funds returned checks.

\_\_\_\_\_\_\_\_\_ (Initials)

**Payment is due in Full at time of treatment unless prior arrangements have been approved.**

Date:

(Patient/Guarantor Printed Name)

Date:

(Patient/Guarantor Signature)

Reviewed by: Date:

(Staff member initials)

NOTICE OF PRIVACY PRACTICES

Dentistry at Greenway

16630 West Greenway Road Ste. 319

Surprise, AZ 85388

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment here at Dentistry at Greenway is to serve our patients with professionalism and caring, being sure at all times to PROTECT the privacy and security of all Protected Health Information.

During the course of serving your interests, it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where information may be shared:

* During treatment, we may find it necessary to consult with a dental laboratory technician
* For payment purposes, we may use the services of a billing service
* During dental care, we may need to consult with your physician or previous dentist
* For payment purposes, we need to supply information requested from your insurance company

We here at Dentistry at Greenway are committed to obeying all Federal, State, and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. The individual, as provided by law, may revoke this written authorization at any time.

If you have any questions or comments regarding your Protected Health Information, feel free to contact our Office Manager.

I have read and understand the Notice of Privacy Practices.

Signed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Patient or Legal Guardian)

**Smile Advantage Discount Plan Registration Form**

**(Non-Insured patients)**

Name of Primary Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Primary Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph# (\_\_\_) \_\_\_\_-\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell# (\_\_\_) \_\_\_-\_\_\_\_\_\_\_

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

List of All Dependents (Dependents are those living in the home only)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

Patient’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_