Union Hills Family Dentistry, PLLC

8110 W Union Hills Drive, Suite 430
Glendale, AZ 85308

Name:_____Nickname:_____Male/Female
Birthday:_____SS#:_____E-Mail_____
Mailing Address:_____City_____Zipcode_____
Home Ph:_____Work Ph:_____Cell Ph:_____
Employer:_____Occupation:_____
Employer Address:_____
Spouse:_____Ph:_____
Emergency contact (local) that does not live with you:_____
Phone:_____Relationship:_____
Whom may we thank for referring you to us:_____

Dental Insurance

Who is responsible for this account?_____
Insurance Co:_____ Group#:_____
Subscriber's Name:_____Birthday:_____
SS#:_____Relationship to Patient:_____
Secondary Insurance:_____

CONSENT FOR TREATMENT

I hereby authorize Union Hills Family Dentistry ("UHFD") to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize UHFD to perform all recommended treatment and to administer the appropriate medications or anesthetics mutually agreed upon. I understand that using anesthetic agents is optional and using them involves certain risks, such as, but not limited to, hematoma, parasthesia, allergic reactions, trismus, or increased heart rate. I will be given an opportunity to discuss any concerns or questions that I may have.

Signature_____Date_____

FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for all charges in this office. All charges will be paid at the time of service unless written financial agreements were made in advance. I understand that this office can not guarantee coverage from insurance companies therefore I will be fully liable for treatment rendered. I agree to pay all late fees, collection costs (40%), attorney's fees, and any other cost that may be incurred to enforce collections of any outstanding amount. If you cancel an appointment within 24 hours of your scheduled appointment time, please be aware that a $75 fee will automatically be charged to your account. This office accepts cash, personal checks, Visa, American Express, Mastercard, & Care Credit. There is a returned check fee of $30.

Signature_____Date_____

Union Hills Family Dentistry, PLLC

Women:

Are you pregnant? □Yes □No Are you nursing? □Yes □No Taking Birth Control? □Yes □No

Allergies:

□ Aspirin □ Codeine □ Latex □Local Anesthesia □ Metals

□Penicillin □ Sulfa Drugs □ Other:_____

Please state the reactions you presented:_____

We would like to get to know you better!

1. Are your teeth sensitive to:

Heat □Yes □No Cold □Yes □No Sweets □Yes □No Biting Pressure □Yes □No

2. Does your food constantly get stuck between certain teeth in your mouth? □Yes □ No
3. Are you dissatisfied with your teeth in any way? □Yes □No

Please explain_____

4. Are you dissatisfied with the way your teeth look? Ex; color, shape, spaces, etc. □Yes □No

Please explain_____

5. If any of your mercury amalgam fillings need replacement, would you prefer to have a more natural, tooth-colored restoration instead? □Yes □No
6. Have you ever had any teeth removed? □Yes □ No
7. How long have these teeth been missing? _____
8. Do your gums bleed when brushing? □Yes □ No
9. Do you avoid any part of the mouth while brushing? □Yes □ No
10. Have you been instructed regarding proper home care? □Yes □ No
11. Do you have an unpleasant taste or odor in your mouth? □Yes □ No
12. Do you smoke? □Yes □ No
13. How often do you brush your teeth? _____Floss? _____
14. Do you want to learn to control dental disease and retain your teeth? □Yes □ No
15. Has the fear of discomfort kept you from regular dental visits? □Yes □ No
16. Are you deeply concerned about the finances required to return your mouth to excellent dental health? □Yes □No
17. When was your last dental appointment? _____
18. What did you have done?_____
19. How long since your last thorough examination with full mouth x –rays?
20. How healthy do you want us to get your mouth?

□ don't really care □ Average □ the best it can be

Addittional Remarks:

_____

_____

Medications: Please list any medications you are currently taking and why

_____

_____

Union Hills Family Dentistry, PLLC

Physician Name_____ Date of Last Visit:_____

Are you in good health? □Yes □No If no, please explain:_____
Have you been hospitalized in the past three years? □Yes □No
If yes, please explain:_____
Have you ever taken any group of drugs collectively referred to as "fen-phen"? □Yes □No
Are you currently taking blood thinners? □Yes □No
Have you ever had a drug addiction or chemical dependency? □Yes □No
Are there any existing health conditions that require you to pre med.? □Yes □No
Please state medication and condition_____
Are you taking any bone strengthening medications? □Yes □No
If yes, please explain_____

Please mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV □Yes □No
Anemia □Yes □No
Arthritis □Yes □No
Artificial Joints □Yes □No
Date: _____
Asthma □Yes □No
Excessive Bleeding □Yes □No
Blood Disease □Yes □No
Specify: _____
Cardiac Conditions □Yes □No
Specify:_____
Cancer □Yes □No
Type: _____
Chemotherapy □Yes □No
Congenital Heart Lesions □Yes □No
Cortisone Treatments □Yes □No
Cough, persistent or bloody □Yes □No
Diabetes □Yes □No
Emphysema □Yes □No
Epilepsy or seizures □Yes □No
Last episode: _____
Fainting or Dizziness □Yes □No
Glaucoma □Yes □No
Headaches □Yes □No
Hepatitis Type____ □Yes □No
Status: _____
High Blood Pressure □Yes □No
Jaundice □Yes □No
Jaw Pain □Yes □No
Kidney Disease □Yes □No
Liver Disease □Yes □No
Low Blood Pressure □Yes □No
Lupus □Yes □No
Pacemaker □Yes □No
Psychiatric Care □Yes □No
Radiation Treatment □Yes □No
Respiratory Disease □Yes □No
Rheumatic Fever □Yes □No
Scarlet Fever □Yes □No
Shortness of Breath □Yes □No
Sinus Trouble □Yes □No
Stroke □Yes □No
Date: _____
Swollen Feet or Ankles □Yes □No
Swollen Neck Glands □Yes □No
Thyroid Problems □Yes □No
Tuberculosis □Yes □No
Tumors, on Head or Neck □Yes □No
Ulcer □Yes □No
Weight Loss, unexplained □Yes □No

Any other conditions we should know about:_____
Signature:_____ Date:_____

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623-878-4460

NOTICE OF PRIVACY PRACTICES

This notice takes effect September 2013 and will remain in effect until we replace it. It describes how health information about you may be used and disclosed by our practice and how you can obtain access to this information. Please review it carefully.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. Our privacy practices are developed to meet requirements as specified by law. If the law changes we will amend our privacy practices to reflect the changes in the law. We must follow the privacy practices that are described in this Notice while it is in effect. 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 laws, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, inform you of changes in the Notice by getting a new signed copy from you, and we will provide copies of the new Notice upon request. 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you, or to a care provider that is overseeing other health needs you may have.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information, or we could require a 3rd party to aid in collection of unpaid balances that are due.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities. Individuals involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We will disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities as required by law, including disclosures to: Prevent or control disease, injury or disability; Report child abuse or neglect; Report reactions to medications or problems with products or devices; Notify a person of a recall, repair, or replacement of products or devices; Notify a person who may have been exposed to a disease or condition; or Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your personal health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your personal health information for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your personal health information to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your personal health information in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your personal health information to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information. It should however be noted that we typically do not participate in research projects and this release is unlikely.

Coroners, Medical Examiners, and Funeral Directors. We may release your personal health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose personal health information to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. By law, we may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving fundraising communications. Our office policy is to NOT fundraise with patient information.

Other Uses and Disclosures of Personal Health Information. If a situation arises that is not covered in the prior sections, we will seek your permission for health information disclosure, unless dictated to do so by law. Your privacy is important to us and we work hard to secure all patient health information to protect individual privacy.

YOUR HEALTH CARE RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information

that we maintain electronically, you still have the right to receive a printed, or if possible, an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for any explanation of our fee structure. If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your person health information by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request, except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have on file.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we decided it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if you disagree with a decision we made about access to your health information or in response to a request you made to amend or strict 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 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.

Privacy Officer: Office Manager

Phone number: 623-878-4460

PRIVACY PRACTICES ACKNOWLEDGEMENT [Retain this page in Patient records]

Privacy Notice Amendment September 2013

I have had the opportunity to read the Patient Privacy Notice for this practice. I understand that I may ask for a copy to take with me at any time, and that an appointed person is available to answer any questions that I may have now, or in the future, regarding the use on my Personal Health Information.

_____ _____ patient

signature date

_____ _____ practice witness

date

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