CANYON STATE DENTAL

2925 E. Riggs Road Suite #2-3 Chandler, AZ 85249 (480) 581-6633

Dental Registration and Treatment

Date_____

Patient Information

Patient Name _____

Preferred Name _____Date of Birth_____

Social Security #_____

Address_____Apt#_____

City _____Zip_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Employer/School_____

☐ Full Time ☐ Part Time ☐ Male ☐ Female

What is the best way to contact you?

☐ Email Me ☐ Call Me ☐ Text Me

Home _____ Cell _____

Work _____Email_____

How did you hear about Canyon State Dental?

☐ Personal Referral_____

☐ Mailing ☐ Yelp ☐ Mouthguard Promo

☐ Google ☐ Building Sign ☐ Insurance

☐ Website ☐ Other_____

Primary Dental Insurance

Subscriber Name _____

Relationship to patient_____

Subscriber's Date of Birth_____

Subscriber's SS/ID#_____

Address (if different from patient) _____

Subscriber's Employer_____

Insurance Company _____

Group #

Secondary Dental Insurance

Subscriber Name _____

Relationship to patient_____

Subscriber's Date of Birth_____

Subscriber's SS/ID#_____

Address (if different from patient) _____

_____

Subscriber's Employer_____

Insurance Company _____

Group #_____

Assignment and Release

If you have Dental Insurance, please read below and sign.

I certify that I, and/or my dependant(s) have insurance coverage with _____and assign
Name of Insurance Company
directly to Canyon State Dental and its associates 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.

Canyon State Dental and its associates may use my health care information and may disclose such information to the above named company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

*All family accounts will be linked together for financial/insurance purposes unless otherwise requested.

_____
Signature of patient or personal representative

_____
Print name of patient or personal representative

_____ _____
Date Relationship to Patient

Emergency Contact Information

Name: _____ Cellular_____Relationship_____

Name: _____ Cellular_____Relationship_____

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Health History Form

Reason for today's visit_____

Former Dentist_____City/State_____

Date of last dental visit_____ Date of last dental x-ray_____

How often do you floss? _____How often do you brush? _____ Do you require a pre-medication? _____

Please check all that apply:

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Blisters/sores/growths on lips or mouth
- ☐ Burning sensation on tongue
- ☐ Chew on one side of mouth
- ☐ Cigarette/pipe/cigar smoking
- ☐ Clicking or popping jaw
- ☐ Dry mouth
- ☐ Foreign objects
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Gums swollen or tender
- ☐ Jaw pain
- ☐ Jaw tiredness
- ☐ Lip or cheek biting
- ☐ Loose teeth/broken fillings
- ☐ Fingernail biting
- ☐ Mouth pain, brushing
- ☐ Orthodontic treatmen
- ☐ Pain around ear
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Mouth breather
- ☐ Have you ever been diagnosed with Sleep Apnea?
- ☐ Have you ever had an overnight sleep study?
- ☐ Do you or have you used a CPAP?
- ☐ Do you wake up in the morning with headaches?
- ☐ Have you been told that you gasp for air or suddenly stop breathing while sleeping?
- ☐ Do you snore?

Health History

Physician's Name _____ Date of Last Visit_____ Other Medical Conditions not listed below_____

Have you ever taken any medications containing bisphosphonates? This includes brands such as Fosamax, Actonel, Didronel, Boniva, Aredia, and Zometa. ☐ Yes ☐ No

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding abnormally, with extractions or surgery
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, persistent/bloody
- ☐ Diabetes
- ☐ Dizziness
- ☐ Bone Density medication
- ☐ Cholesterol medication
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis Type _____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Special Diet
- ☐ Stroke
- ☐ Swollen Feet/Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or growth on head or neck
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Weight Loss/Gain

Do you wear contact lenses? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Due Date:

Are you nursing? ☐ Yes ☐ No

Medication

List any medication you are currently taking and the Correlating diagnosis: _____

_____

☐ Medical Marijuana

Allergies

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Other_____

_____

_____

I authorize and give consent to perform dental services agreed between Canyon State Dental and its associates and patient and/or parent or guardian to be necessary or advisable including the use of anesthesia and other medication as indicated. I certify to the accuracy of the above statements regarding my medical and dental history. Payment for all treatment and services rendered are my responsibility.

_____ _____ _____

Signature of patient, parent, guardian or personal representative | Printed name of patient, parent, guardian or personal representative | Date

CANYON STATE DENTAL

FINANCIAL POLICIES

In order to enhance communication and promote understanding regarding this office's Financial Policies, please read through the following information. After reading, please provide your signature at the bottom indicating that you fully understand these policies. This form must be signed in order to proceed with your scheduled appointment. If you have any questions or concerns, please ask to speak with the Office Manager. Thank you!

- **Insurance:** We are happy to bill both primary and secondary insurances as a **courtesy** for our patients. It must be understood that each patient is ultimately responsible for the cost of services rendered. We will do our best to estimate accurate insurance coverage and patient portions due; however, if the insurance company does not pay the full amount anticipated, the patient is responsible for the difference. Payment would be expected within 30 days of receiving a statement.
- **Patient Payment:** The patient portion due for services rendered is expected at the time of service unless *previous* arrangements have been made. We accept cash, checks and all major credit cards.
- **Financing:** We have financing options available through Care Credit and Lending Club. If you have an interest in these options, please consult with the office manager prior to the date of scheduled treatment.
- **No Shows/Missed Appointments:** We request notice to cancel or reschedule an appointment of at least 48 hours (2 businesses days) prior to the appointment as scheduled. If appropriate notice is not given, a charge of $50 per hour of scheduled appointment will be assessed to the patient's account (I.E. 1hr or less appointment= $50 charge, 2hr appointment= $100, etc).
- **Refunds for Unfinished Treatment:** If a patient decides to discontinue treatment after it has been started, a full refund will not be given. Individual circumstances may be discussed with the office manager and/or dentist.
- **Credits on an Account:** If an insurance company pays more than anticipated creating a credit for the patient, we are happy to either refund the patient or leave the credit on the account to be applied toward future treatment.
- **Collections:** On occasion, after repeated attempts to collect a balance due, we may need to turn an account over to a collections agency. Should this occur, it is agreed that the financially responsible party listed below shall pay all finance charges, collection cost, attorneys fees, and any other costs that may be incurred to enforce collection of any amount outstanding.

Patient Name:_____

Patient/Guardian Signature :_____ Date:_____

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www.canyonstatedental.com | P: (480) 581-6633

Canyon State Dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgment****

If the patient is under 18 years of age, a parent or legal guardian must sign.

I, _____, have received a copy of this office's Notice of Privacy Practices.
{Please Print Patients Name}

_____
{Signature of Patient or Parent/Legal Guardian}

_____
{Date}

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

PATIENT ACKNOWLEDGMENT

List Names:

_____

_____

_____

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Patient reviewed Privacy Practices but elected not to take a copy home
- ☐ Other (Please Specify)

Employee signature: _____ Date: _____

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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.

Copies of this notice available upon request.

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 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.

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).

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 $1.00 for each page, $20.00 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.

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: Amy Manzo Telephone: (480) 581-6633

Address: 2925 E. Riggs Road Suite #2-3 Chandler, AZ 85249

CANYON STATE DENTAL

Smile Evaluation Form

Michael Dickerson, DMD

Patient Name: _____ **Date:** _____

Are you happy with the appearance of your teeth, gums and smile?..... Yes ☐ No ☐

Would you like to discuss enhancing the appearance of your smile? ..... Yes ☐ No ☐

What don't you like about your smile?

Would you like to discuss how to make your teeth WHITE? ..... Yes ☐ No ☐

Would you like to discuss how to Straighten your teeth? ..... Yes ☐ No ☐

Do you snore at night? ..... Yes ☐ No ☐