



FLOTTED
FAMILY DENTISTRY

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____
(Last) (MI) (First)

Mr. Mrs. Ms. Dr. I prefer to be called: _____

Birthdate: _____ SS#: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Single: Married: Divorced: Widowed: Separated: _____

Home Phone: _____ Mobile: _____

Work Phone: _____ Email: _____

Employer: _____ Occupation: _____

What is your preferred method of contact? _____

Whom may we thank for referring you?

Other family members seen by us: _____

Responsible Party's Information

His/Her Name: _____
(First) (MI) (Last)

Birthdate: _____ SS#: _____

Employer: _____ Occupation: _____

Home Phone: _____ Mobile: _____

Work Phone: _____ Email: _____

Emergency Contact

In the event of an emergency, who would you like us to contact?

Name: _____

Relationship: _____

Home Phone: _____ Mobile: _____

Work Phone: _____ Email: _____

Dental Insurance

Primary Dental Insurance

Name of Insurance Co: _____

Address: _____

Phone #: _____

Group #: _____

Insured's Name: _____

Relation: _____

Insured's Birthday: _____ Insured's SS#: _____

Insured's Employer: _____

Additional Dental Insurance

Name of Insurance Co: _____

Address: _____

Phone #: _____

Group #: _____

Insured's Name: _____

Relation: _____

Insured's Birthday: _____ Insured's SS#: _____

Insured's Employer: _____

Preferred Pharmacy

Name of Pharmacy: _____

Address: _____

Phone #: _____

Physician's Name: _____ Physician's Phone #: _____

Date of last visit: _____ Have you had any serious illnesses or operations? Yes No

If yes, describe _____

Are you currently under physician care? Yes No If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____

Have you ever taken Fen-Phen/Redux? Yes No

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. Yes

Do you smoke or use other tobacco/smokeless products? Yes No Check all that apply: Cigarettes Cigars Vape

Marijuana Chew

Other _____

Women: Are you pregnant? Yes No Nursing? Yes No
Taking birth control pills? Yes No

Check (✓) yes or no whether you have had any of the following:

- | | | |
|---|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No AIDS/HIV Positive | <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker/Heart surgery |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anaphylaxis | <input type="checkbox"/> Yes <input type="checkbox"/> No Fainting | <input type="checkbox"/> Yes <input type="checkbox"/> No Psychiatric care |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No Food allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No Rapid weight gain loss |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis, Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No Radiation treatment |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial heart valves | <input type="checkbox"/> Yes <input type="checkbox"/> No Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No Respiratory disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic/Scarlet fever |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Shingles |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Atopic (allergy prone) Describe: _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Hemophilia/Abnormal bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of breath |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Back problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No Skin rash |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Blood disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No Spina Bifida |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No High blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chemical dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No Jaw pain | <input type="checkbox"/> Yes <input type="checkbox"/> No Surgical implant |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney disease or malfunction | <input type="checkbox"/> Yes <input type="checkbox"/> No Swelling of feet or ankles |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Circulatory problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Liver disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid disease of malfunction |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cortisone treatments | <input type="checkbox"/> Yes <input type="checkbox"/> No Material allergies
(latex , wool, metal, chemicals) | <input type="checkbox"/> Yes <input type="checkbox"/> No Tobacco habit |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cough, persistent | <input type="checkbox"/> Yes <input type="checkbox"/> No Mitral valve prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No Tonsillitis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cough up blood | <input type="checkbox"/> Yes <input type="checkbox"/> No Nervous problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes | | <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcer/Colitis |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No Venereal disease |

Does patient have drug allergies? If yes, list all:

Is patient currently taking any medications? If yes, list all:

Medication	Dosage	Reason for Taking Medication

Patient Signature: _____

Date: _____

Doctor's Signature: _____

Date: _____



What would you like us to do today? _____

Are you in dental discomfort today? Yes No

Former Dentist: _____ Phone: _____

Date of last dental care: _____ Date of last x-rays: _____

Check (✓) yes or no if you have had problems with any of the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bad breath | <input type="checkbox"/> Yes <input type="checkbox"/> No Grinding or clenching teeth | <input type="checkbox"/> Yes <input type="checkbox"/> No Sensitivity to hot |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding gums | <input type="checkbox"/> Yes <input type="checkbox"/> No Loose teeth or broken fillings | <input type="checkbox"/> Yes <input type="checkbox"/> No Sensitivity to sweets |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Clicking or popping jaw | <input type="checkbox"/> Yes <input type="checkbox"/> No Periodontal treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No Sensitivity when biting |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Food collection between teeth | <input type="checkbox"/> Yes <input type="checkbox"/> No Sensitivity to cold | <input type="checkbox"/> Yes <input type="checkbox"/> No Sores or growths in mouth |

How often do you brush? _____ How often do you floss? _____

How do you feel about the appearance of your teeth? _____

Do you wish your teeth were straighter? Yes No

Do you wish your teeth were whiter? Yes No

Are you unhappy with any fillings, crowns or bridges? Yes No

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Yes No

Other information about your dental health or previous treatment _____

I have reviewed the information on the questionnaires, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of the signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: _____

Date: _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

Doctor's Signature: _____

Date: _____

Dear Patient:
This notice is not meant to alarm you. Quite the opposite! It is our desire to communicate to you that we are taking seriously Federal law (HIPAA—Health Insurance Portability and Accountability Act) enacted to protect the confidentiality of your health information. We never want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

Why do you have a privacy policy? Very good question!

The Federal government legally enforces the importance of the privacy of health information largely in response to the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we follow to protect your health information when we use it.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your **HEALTH INFORMATION** only for the purposes of providing your treatment, obtaining payment, conducting healthcare operations, and as otherwise described in this notice.

How your HEALTH INFORMATION may be used To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with care. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care. In addition, we may share your health information with pharmacies or other healthcare personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best care. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

To Business Associates

We have contracted with one or more third parties (referred to as a business associate) to use and disclose your health information to perform services for us, such as billing services. We will obtain each business associate's written agreement to safeguard your health information.

NOTICE OF PRIVACY PRACTICES

Federal law generally permits us to make certain uses or disclosures of health information without your permission. Federal law also requires us to list in the Notice each of these categories of uses or disclosures. The listing is below.

As Required By Law

We may use or disclose your health information as required by any statute, regulation, court order or other mandate enforceable in a court of law.

Abuse or Neglect

We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official determines that informing you would not be in your best interest.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best judgment when sharing your health information only when it will be important to those participating in providing your care.

Workers' Compensation Purposes

We may disclose your health information as required or permitted by State or Federal workers' compensation laws.

Judicial and Administrative Proceedings

We may disclose your health information in an administrative or judicial proceeding in response to a subpoena or a request to produce documents. We will disclose your health information in these circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.

Incidental Uses and Disclosures

We may use or disclose your health information in a manner which is incidental to the uses and disclosures described in this Notice.

Health Oversight Activities

We may disclose your health information to a government agency responsible for overseeing the health care system or health-related government benefit program.

To Avert A Serious Threat To Health or Safety

We may use or disclose your health information to reduce a risk of serious and imminent harm to another person or to the public.

To The U.S. Department of Health and Human Services (HHS)

We may disclose your health information to HHS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

For Research

We may use or disclose your health information for research, subject to conditions. "Research" means systemic investigation designed to contribute to generalized knowledge.

In Connection With Your Death Or Organ Donation

We may disclose your health information to a coroner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs.

If applicable State law does not permit the disclosure described above, we will comply with the stricter State law.

Authorization to Use or Disclose Health Information

We are required to obtain your written authorization in the following circumstances: (a) to use or disclose psychotherapy notes (except when needed for payment purposes or to defend against litigation filed by you); (b) to use your PHI for marketing purposes; (c) to sell your PHI; and (d) to use or disclose your PHI for any purpose not previously described in this Notice. We also will obtain your authorization before using or disclosing your PHI when required to do so by (a) state law, such as laws restricting the use or disclosure of genetic information or information concerning HIV status; or (b) other federal law, such as federal law protecting the confidentiality of substance abuse records. You may revoke that authorization in writing at any time.

PATIENT RIGHTS

You have the following rights related to your health information.

Restrictions

You have the right to request restrictions on the use or disclosure of your health information for treatment, payment, or healthcare operations in addition to the restrictions imposed by federal law. Our office is not required to agree to your request, unless (a) you request that we not disclose your PHI to a health insurance company, Medicare or Medicaid for payment or healthcare operations purposes; (b) you, or someone on your behalf, has paid us in full for the healthcare item or service to which the PHI pertains; and (c) we are not required by law to disclose to the insurer, Medicare, or Medicaid the PHI that is the subject of your request, but we will endeavor to honor reasonable requests. We generally are not required to agree to a requested restriction. Our office will honor your request that we not disclose your health information to a health plan for payment or healthcare operation purposes if the health information relates solely to a healthcare item or service for which you have paid us out-of-pocket in full.

Confidential Communications

You have the right to request that we communicate with you by alternative means or at an alternative location. You may, for example, request that we communicate your health information only privately with no other family members present or through mailed communications that are sealed. We will honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable, cost-based fee to duplicate and assemble your copy. If there will be a charge, we will first contact you to determine whether you wish to modify or withdraw your request.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe the information to be changed and your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete. If we deny your request, we will provide you with a written explanation of the denial.

Accounting of Disclosures of Your Health Information

You have the right to ask us for a description of how and where your health information was disclosed. Our documentation procedures will enable us to provide information on health information disclosures that we are required to disclose to you. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We will provide the first accounting during any 12-month period without charge. We may charge a reasonable, cost-based fee for each additional accounting during the same 12-month period. If there will be a charge, the Privacy Official will first contact you to determine whether you wish to modify or withdraw your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

Receive Notice of a Security Breach

You have the right to receive notification of a breach of your unsecured health information.

Changes to the Notice

We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

Complaints

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. We will not retaliate against you for submitting a complaint. Please let us know of your concerns or complaints in writing by submitting your complaint to our Privacy Officer.

Patient Signature (or Guardian)

Date



1735 W. Hunt Hwy. Ste. C-103
San Tan Valley, AZ 85143
Phone: (480) 581-7681

HIPAA CONSENT FORM

Patient Name (please print): _____ Date: _____

Patient DOB: _____

HIPAA- Notice of Privacy Practices

HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of the notice Privacy Practice is to explain how Flossed Family Dentistry may use or disclose your healthcare information. The notice also explains the rights that you are guaranteed under HIPAA regulations. Flossed Family Dentistry is required by the HIPAA Privacy Rule to distribute this notice to you and obtain acknowledgement that you have received the notice. Signing below indicates that you have received the Notice of Privacy Practices. I hereby acknowledge that I have received or requested to receive a copy of Flossed Family Dentistry Notice of Privacy Practices.

Patient Signature (or Guardian)

Permission to Share Medical/Dental Information:

(including a spouse: optional- you may leave this BOTTOM portion blank)

My medical/dental information may be obtained and/or exchanged written or verbally to:

(Printed Name and Relationship)

Patient Signature (or Guardian)

Date