New River - Anthem Family Dentistry

WELCOME

PATIENT INFORMATION

Name _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Social Security Number _____ Birthdate _____

Check Appropriate Box ❑ Minor ❑ Single ❑ Married ❑ Other

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name_____ Employer _____ Work Phone _____

If Patient is a Student, Name of School/College _____ City _____ State _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone # _____

INSURANCE

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security Number _____ Date Employed _____

Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____

Address _____ City _____ State _____ Zip _____

INTERNET

INTERNET AUTHORIZATION

If you would like to be able to log onto our website www.anthemdentistry.com to see your account, upcoming appointments and more, please provide us with your _____.
E-mail Address

I Authorize New River Anthem Family Dentistry to make my account information available on the internet for my use only.

_____ _____
Signature Date

PRIVACY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's notice of Privacy Practices
Patients name

_____
Please Print Patient or Parent name

_____ _____
Signature Date

Medical & Dental History

DENTAL HISTORY

Reason for Today's Visit: _____

Date of Last Dental Visit: _____ Date of Last X-Rays: _____

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

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

MEDICAL HISTORY

Medical Physician's Name: _____ Address: _____

Have you been under the care of a physician/hospital in the last 2 years? _____ For? _____

Please list any major surgeries or illnesses you've had in the last 2 years: _____

_____

Women: Are you pregnant or nursing? ❑ Yes ❑ No Are you taking hormones or birth control? ❑ Yes ❑ No

Do you smoke or use tobacco? _____ How long? _____

Have you ever been told by a doctor you need to take medication prior to dental treatment? ❑ Yes ❑ No

Are you now taking or have you taken any prescription medications during the past year? ❑ Yes ❑ No

If Yes, please list: _____

_____

Are you allergic or sensitive to any drugs or medications? ❑ Yes ❑ No If yes, please list: _____

Please check (✓) **Yes or No** for each item.

Yes	No		Yes	No		Yes	No	
❑	❑	Abnormal Blood Pressure	❑	❑	Diabetes	❑	❑	Organ Transplant
❑	❑	Allergies	❑	❑	Epilepsy or Seizures	❑	❑	Polio
❑	❑	Anemia	❑	❑	Fainting	❑	❑	Prolonged Bleeding
❑	❑	Angina	❑	❑	Glaucoma	❑	❑	Prolonged Cough
❑	❑	Arthritis	❑	❑	Heart Disease	❑	❑	Psychiatric Treatment
❑	❑	Artificial Heart Valves/Pacemaker	❑	❑	Heart Murmur	❑	❑	Radiation Therapy
❑	❑	Artificial Joints	❑	❑	Hepatitis	❑	❑	Rheumatic Fever
❑	❑	Asthma	❑	❑	Herpes	❑	❑	Sickle Cell Anemia
❑	❑	Blood Transfusions	❑	❑	HIV	❑	❑	Stroke
❑	❑	Cancer	❑	❑	Jaundice	❑	❑	Thyroid Disease
❑	❑	Chemical Dependency	❑	❑	Kidney Disease	❑	❑	Tuberculosis
❑	❑	Chemotherapy	❑	❑	Latex Allergy	❑	❑	Ulcers or Sores
❑	❑	Congenital Heart Lesions	❑	❑	Liver Disease	❑	❑	Venereal Disease
						❑	Other: _____	

AUTHORIZATION & RELEASE

I have read the above questions and the answers I have given are true and to the best of my knowledge, I am indicating my consent for routine dental procedures such as X-rays, cleanings, fillings, crowns, and local anesthesia, as needed by signing below.

_____ _____

Patient or Parental Signature Date

_____ _____

Dentist's Signature Date

Provider Review:	
Date	Initials

Patient Identification:

Name: _____ DOB: _____

Darren L. Flowers, D.M.D.

Anthem Medical Plaza
3618 W. Anthem Way, Ste. #D-132
Anthem, AZ 85086

Patient Name:_____ D.O.B.:_____

Responsible Party (If not patient)

Name:_____ Phone:_____

Address:_____ D.O.B.:_____

City/State/Zip:_____ S.S.N.:_____

FINANCIAL AGREEMENT
Payment in full for all charges is required at time of visit, unless prior arrangements have been made.

INSURANCE FILING
You, the patient are ultimately responsible for payment in full on your account, not the insurance company. We do, however, file dental insurance claims as a courtesy to our patients. We can only make *estimates* regarding your insurance benefits based on the information provided by you and the insurance company. In the event your insurance company does not pay as much as expected, the remaining balance is due and payable immediately by you, the patient.

ASSIGNMENT OF INSURANCE BENEFITS
I/we hereby assign directly to Dr. Flowers insurance benefits otherwise payable to me/us. I/we hereby authorize the release of any information relating to any claims. I/we understand I/we are financially responsible for charges not paid by this assignment.

DELINQUENT ACCOUNTS
All delinquent accounts (30 days or older) are subject to reasonable service charges and/or legal interest rates.

COLLECTION PROCEEDINGS
In the event your account is turned over to a collection agency for non-payment or other delinquency, you will be responsible for payment of any collection costs **(30%)** and/or attorney fees, in addition to the balance owed. Any account turned over to a collection agency forfeits any past special fees and/or discounts. Such special fees and/or discounts will be reversed and you will be responsible for payment of regular fee for procedures at the time of service.

FAILED APPOINTMENTS
Failed appointments (less than 24 hours notice) are a significant contributor to rising heath care costs. Individuals who fail to show for a confirmed appointment may be assessed a $50.00 fee.

I have completely read and understand the contents of this agreement. I agree to comply with all policies.

Patient/Responsible Party Signature Date

_____ _____

Darren L. Flowers, D.M.D.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DICLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

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 12/01/2002 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and applicable law permits the terms of this Notice at any time, provided such changes. 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 at the end of this Notice.

USES AND DICLOSURES 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 operation, 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 effect any use or disclosure 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 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 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 another crime. 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 authorize federal officals 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 $0.10 for each page, $15.00per 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. (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.

Restrictions: You have the right to request that we additional restrictions on our use or disclose 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 location. (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 hat 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 disclose 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 with the U.S. Department of Health and Human Services upon request.

We support your right to 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: *Jennifer Eklund*

Telephone: 623-551-8000 Fax: 623-465-4604 E-mail: newriverdentist@qwest.net

Address: Anthem Medical Plaza, 3618 W. Anthem Way, Ste D132, Anthem, AZ 85086