



PERSONAL INFORMATION

Full Name _____ Today's Date _____

Mr. Mrs. Ms. Rev. Dr.

I prefer to be addressed as _____ Birthdate _____

Whom may we thank for referring you to our practice?

Address _____

Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____

E-mail address _____

Preferred contact E-mail Home Phone Work Phone Cell Phone

Best time to call _____

Employer _____

Occupation _____

Spouse / Partner _____

Cell Phone _____

Additional Emergency contact _____

Phone _____

Others who may bring my child to their appointment _____

Last dental visit _____

with Dr. _____

PLEASE SELECT ONE BOX ON EACH LINE

My mouth is very comfortable My mouth is moderately comfortable My mouth is uncomfortable

My smile is excellent I would like to change my smile I am unconcerned about my smile

I will do whatever I must to keep my teeth I want to keep my teeth but only within a certain budget of time and money I am Indifferent

I've done the dentistry recommended to me I've NOT done dentistry recommended to me

Never been recommended

MY DENTAL HEALTH IS Excellent Good Fair Poor

Why have you made this appointment

Account name preference: Self Spouse

Payment preference: Check Credit card (Visa, MC, AMEX)



AUTHORIZATION FOR USE AND IMAGE RELEASE

For and in consideration of my engagement as a patient in the Mountain Dental Arts Practice, I hereby grant Mountain Dental Arts, its heirs, legal representatives and assigns, and those acting with its authority and permission, the absolute right and permission to copyright in its name or otherwise, to use, re-use, publish, re-publish, reproduce or circulate photographs and/or video of myself, in whole or in part, without restrictions as to alterations, in conjunction with my own name or any assumed name, or reproduction thereof, made through any and all media now or hereafter known, for illustration, promotion, or any purpose whatsoever. I further consent to the use of any text used in conjunction therewith. In addition, I authorize Mountain Dental Arts and the Mountain Dental Arts Practice, its employees and agents, to use and disclose my name, face, voice, video or film image and my personal health information including the treatment I am receiving or have received in the Mountain Dental Arts Practice.

I hereby waive any right that I may have to inspect or approve the finished product, or products and the text, copy, or other matter which may be used in conjunction therewith, or to the use to which it may be applied. I agree that this release validates use of my photographs, videos, and audio in any means, including but not limited to, promotional materials, contests or advertising and including but not limited to, the use of such images and audio on products, and for the purpose of trade, and I hereby consent to the use of any printed, graphic, photographic, electronic, computer generated, or any other accompanying matter in any media form. I hereby agree to release, discharge and agree to save harmless Mountain Dental Arts Practice, its heirs, legal representatives and assigns, and all persons acting under its permission or authority, or those for whom it is acting, from any liability by virtue of blurring, distortion, alteration, optical illusion, electronic manipulation, or use in composite form, whether intentional or otherwise, that may occur during publication or in any subsequent processing thereof, including without limitation any claims for libel or invasion of privacy. I hereby warrant that I have read the above authorization, release, and agreement prior to its execution and I am fully familiar with the contents thereof. This release shall be binding upon me, my heirs, my legal representatives and assigns.

Understanding that Mountain Dental Arts Practice are relying thereon, I hereby represent and warrant that I am at least 18 years of age and am of lawful age to contract and am competent to contract in my own name insofar as this agreement is concerned.

I do not have to sign this authorization. When my information is used or disclosed pursuant to this authorization it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Mountain Dental Arts Practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at: Mountain Dental Arts P.o. Box 2040 Pinetop, Az 85935

"I acknowledge that I have received the Authorization for Use and Image Release"

Name (print) Signature Date

Witness (print) Signature Date



NOTICE OF PRIVACY PRACTICE SUMMARY - HIPPA

This summary discloses how Healthcare information about you may be used by Mountain Dental Arts. A full notice of your privacy rights has been provided to you.

Treatment, Payment, Operations. We may use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

Uses and Disclosures for Appointment Reminders. We may use and disclose your Healthcare information to contact you as a reminder that you have an appointment at the office. If you request that such communications be made confidentially, please contact our office in writing. We will accommodate all reasonable requests.

Authorization for Use and Disclosure. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Public health, research, health and safety, government, works compensation. We may disclose your information for public health activities, research, health and safety, governmental function, and in order to comply with workers compensation laws and regulations.

Rights. You have a right to inspect and copy information used to make decisions about your care, to request an amendment of the information, to an accounting of disclosures, to request communication with you by alternate means, to request restrictions on the information we use, and to revoke your authorization for release of information.

Organization duties. We must maintain the privacy of protected health information, provide you with notice of our legal duties and privacy practice with respect to your health information, abide by the terms of the notice, notify you if we are unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations, and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

“I acknowledge that I have received the full Privacy Notice.”

Name (print) Signature/ Date

Witness Signature/ Date



Patient Name: _____ DATE of BIRTH ____/____/____

Social Security #: _____ Employer: _____

Dental Benefits Carrier: _____

ID# _____ GROUP# _____

If patient is under the age of 18, name of individual who is financially responsible for Patient:
NAME: _____

If you have dental insurance, we will file the claims for you, as a complimentary service. It is very important that the correct insurance information is provided at the time of the patient's appointment. If this information changes, it is the **PATIENT'S RESPONSIBILITY** to update Mountain Dental Arts at the earliest convenience. While we do our best to verify dental benefits prior to your first appointment, this does not guarantee coverage or payments to Mountain Dental Arts. We do accept payments from the dental insurance companies; however, we are **NOT** contracted with them. It is a contract between you, your employer and the insurance company.

If requested, we will provide you with a verbal **ESTIMATE** of your out of pocket expense for any treatment planned by the doctor. However, please understand that these are strictly estimates and are not a guarantee that your insurance company will reimburse us/you according to these estimates.

Please note that any difference in payment from your insurance company and your account balance is *your responsibility*. While the filing of insurance claims is a courtesy that we extend to all our patients, all charges are your responsibility from the date the services are rendered. If difficulty arises with a payment from the insurance company, we will ask that you contact your carrier to rectify the problem. *All expected insurance balances remaining unpaid after 90 days from the date of service becomes the immediate responsibility of the patient/or account holder.*

Payment for co-pays and/or deductibles is due at the time services are provided.

Any balance older than 90 days will be subject to interest charges of 1.5% per month, from the date of service, until the account is paid in full. If a payment has not been received on the account during the 90 days, the account risks being sent to a collection agency or an attorney, additional collection fees will be applied to any unpaid balance. **Any attorney or collections fees incurred due to delinquency in payment or collection efforts will also be charged to you including court costs and fees. Any personal checks returned unpaid or with non-sufficient funds (NSF) will incur a \$30.00 NSF check fee and may also subject you to court costs and attorney fees.**

We request a 48-hour cancellation notice for scheduled appointments. A cancellation fee of \$40.00 may be charged if a 48-hour notice is not given.

I acknowledge having read this Financial Responsibility Form in its entirety and agreed to be bound by all the terms and conditions herein.

Please PRINT your name

Today's Date

Please SIGN your name



SCREENING FOR OBSTRUCTIVE SLEEP APNEA

MEDICAL HISTORY

- | | |
|--|---|
| <input type="checkbox"/> DEPRESSION
<input type="checkbox"/> MORNING HEADACHES
<input type="checkbox"/> MEMORY AND LEARNING PROBLEMS
<input type="checkbox"/> TROUBLE CONCENTRATING
<input type="checkbox"/> MOOD SWINGS, PERSONALITY CHANGE
<input type="checkbox"/> CHRONIC NASAL CONGESTION
<input type="checkbox"/> FAMILY HISTORY OF SNORING OF SLEEP APNEA | <input type="checkbox"/> HIGH BLOOD PRESSURE
<input type="checkbox"/> STROKE
<input type="checkbox"/> HEART DISEASE
<input type="checkbox"/> ATRIAL FIBRILLATION OR OTHER PROBLEMS W/ HEART RHYTHM
<input type="checkbox"/> ACID REFLUX
<input type="checkbox"/> DECREASED SEX DRIVE |
|--|---|

SLEEP HISTORY

- | | |
|---|--------|
| HAVE YOU EVER HAD A SLEEP STUDY OR BEEN TOLD TO GET ONE? | YES/NO |
| HAVE YOU EVER BEEN DIAGNOSED WITH A SLEEP DISORDER? | YES/NO |
| DO YOU WAKE UP IN THE MORNING FEELING UNREFRESHED | YES/NO |
| ARE YOU A RESTLESS SLEEPER? | YES/NO |
| DO YOU CATCH YOURSELF NODDING OFF DURING THE DAY? | YES/NO |
| DOES YOUR BED PARTNER SLEEP IN ANOTH ROOM BECAUSE OF YOUR SNORING? | YES/NO |
| DO YOU WAKE UP FREQUENTLY TO URINATE DURING THE NIGHT? | YES/NO |
| DO YOU GRIND YOUR TEETH AT NIGHT | YES/NO |
| HAVE YOU EVER HAD JAW LOCKING CLICKING/PAIN, TOOTH SENSITIVITY OR BEEN TOLD YOU HAVE TMJ? | YES/NO |
| DO YOU HAVE A DRY MOUTH OR A SORE THROAT WHEN YOU WAKE UP? | YES/NO |
| HAVE YOU EVER USED A CPAP MACHINE? | YES/NO |
| ARE YOU CURRENTLY USING A CPAP MACHINE? | YES/NO |
| IF YES, DO YOU USE YOUR CPAP LESS THAN 5 TIMES PER WEEK | YES/NO |
| HAVE YOU TRIED CPAP AND ARE LOOKING FOR OTHER TREATMENT OPTIONS? | YES/NO |



DENTAL HISTORY

HOW WOULD YOU RATE THE CONDITION OF YOUR MOUTH: EXCELLENT __ GOOD __ FAIR __ POOR __

DATE OF MOST RECENT DENTAL EXAM: _____ DATE OF MOST RECENT XRAYS: _____

DATE OF MOST RECENT PROCEDURE: _____ PROCEDURE DONE: _____

I ROUTINELY SEE MY DENTIST EVERY: 3MO __ 4MO __ 6MO __ 12MO __ NOT CURRENTLY __

WHAT IS YOUR IMMEDIATE CONCERN:

1. ARE YOU FEARFUL OF DENTAL TREATMENT? HOW FEARFUL FRIM 1-10? _____

2. HAVE YOU HAD AN UNFAVORABLE DENTAL EXPERIENCE _____

3.HAVE YOU EVER HAD COMPLICATIONS FROM PAST DENTAL TREATMENT? _____

4.DO YOU HAVE TROUBLE GETTING NUMB? OR HAD ANY REACTIONS TO LOCAL ANESTHETICS?

5.HOW WOULD YOU LIKE TO IMPROVE YOUR SMILE? _____

6.HAVE YOU BEEN DISAPPOINTED WITH PREVIOUS DENTAL WORK? _____

7.DO YOU HAVE PROBLEMS WITH YOUR JAW? _____

8.DO YOU HAVE ANY PROBLEMS CHEWING? _____

9.DO YOU CLINCH OR GRIND YOUR TEETH ANYTIME OF THE DAY? _____

10.DO YOU WAKE UP WITH SORENESS OR SENSITIVITY? _____

11. DOES THE SALIVA IN YOUR MOUTH SEEM TO LITTLE OR DO YOU HAVE DIFFICULTY SWALLOWING ANY FOOD? _____

12. ARE ANY TEETH SENSITIVE TO HOT, COLD, BITING, SWEETS OR AVOID BRUSHING ANY PART OF YOUR MOUTH? _____

13.DO YOU GET FOOD CAUGHT BETWEEN ANY TEETH? _____

14.DO YOUR GUMS BLEED WHEN BRUSHING OR FLOSSING? _____

15. HAVE YOU EVER BEEN TREATED FOR GUM DISEASE OR BEEN TOLD YOU HAVE LOST BONE AROUND YOUR TEETH? _____

COMMENTS:

PATIENT SIGNATURE _____ DATE _____



MEDICAL HISTORY

Although dental personnel primarily treat the area in & around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physicians care now? Y/N _____

Have you ever been hospitalized or had a major operation? Y/N _____

Have you ever had a head or neck injury? Y/N _____

Are you taking any medications or drugs? Y/N _____

Are you on a special diet? Y/N _____

Do you use Tobacco? Y/N _____

Do you use controlled substances? Y/N _____

Are you pregnant or trying to get pregnant? Y/N Nursing? Y/N Taking oral contraceptive? Y/N

Are you allergic to the following? **Aspirin Y/N Penicillin Y/N Codeine Y/N Acrylic Y/N Metal Y/N**

Latex Y/N Sulfa Drugs Y/N Local Anesthetics Y/N Other _____

Do you have or have you had, any of the following?

- | | | |
|--------------------------------|---------------------------|----------------------------------|
| AIDS/HIV POSITIVE Y/N | GLAUCOMA Y/N | SHINGLES Y/N |
| ALZHEIMER'S DESEASE Y/N | HAY FEVER Y/N | SICKLE CELL DISEASE Y/N |
| ANAPHYLAXIS Y/N | HEART MURMUR Y/N | SINUS TROUBLES Y/N |
| ANGINA Y/N | HEART PACEMAKER Y/N | STOMOACH/ INTESTINAL DISEASE Y/N |
| ARTHRITIS/ GOUT Y/N | HEAERT ATTACK Y/N | STROKE Y/N |
| ARTIFICIAL JOINT Y/N | HEMOPHILIA Y/N | SWELLING OF LIMBS Y/N |
| ASTHMA Y/N | HEPATITIS A Y/N | THYROID DISEASE Y/N |
| BRUISES EASILY Y/N | HEPATITIS B OR C Y/N | TONSILLITIS Y/N |
| CANCER/ TUMORS Y/N | HIGH BLOOD PRESSURE Y/N | TUBERCULOSIS Y/N |
| CHEMOTHERAPY/ RADIATION Y/N | HIGH CHOLESTEROL Y/N | ULCERS Y/N |
| COLD SORES/FEVER BLISTERS Y/N | HIVES OR RASH Y/N | |
| CONGENITAL HEART DISORDERS Y/N | HYPOGLYCEMIS Y/N | |
| DIABETES Y/N | IRREGULAR HEARTBEAT Y/N | |
| DRUG ADDICTION Y/N | KIDNEY PROBLEMS Y/N | |
| EMPHYSEMA Y/N | LEUKEMIA Y/N | |
| EPILEPSY OR SEIZURES Y/N | LIVER DISEASE Y/N | |
| EXCESSIVE BLEEDING Y/N | LOW BLOOD PRESSURE Y/N | |
| EXCESSIVE THIRST Y/N | LUNG DISEASE Y/N | |
| FAINING SPELLS/ DIZZINES Y/N | MITRAL VALVE PORLAPSE Y/N | |
| FREQUENT COUGH Y/N | OSTEOPROSIS Y/N | |
| FREQUENT HEADACHES Y/N | PSYCHIATRIC CARE Y/N | |

HAVE YOU HAD ANY SERIOUS ILLNESS NOT LISTED ABOVE? _____

COMMENTS _____

SIGNATURE _____ DATE _____