Welcome To Our Practice

HAVASU DENTAL Center LLC

PATIENT INFORMATION

Today's Date_____

Name_____ Birthdate_____ SSN_____
Address_____ City_____ State_____ Zip_____
Mailing Address (If different from above) Sex □ M □ F □Married □Widowed □Single □Minor
Address_____ City_____ State_____
Zip_____
E-mail_____ May we contact you via email? _____ Text Message? _____
Home Phone_____ Work_____ Cell_____
Whom may we thank for referring you? _____
Person to contact in case of emergency_____ Phone_____

RESPONSIBLE PARTY

Name of Person Responsible For This Account_____ Relation_____
Address_____ Phone_____
Birthdate_____ Driver's License_____ E-mail_____
Currently a patient in our office? □ Yes □ No

PRIMARY INSURANCE

Name of Insured_____ Relation to Patient_____
Driver's License #_____ Birthdate_____ SSN_____
Employer_____ Employer Address_____
Insurance Company_____ Insurance Phone_____
Member ID #_____ Group #_____

SECONDARY INSURANCE

Name of Insured_____ Relation to Patient_____
Driver's License #_____ Birthdate_____ SSN_____
Employer_____ Employer Address_____
Insurance Company_____ Insurance Phone_____
Member ID #_____ Group #_____

DENTAL HISTORY

Reason for today's visit_____ Date of last dental care_____
Former Dentist_____ Date of last dental X-rays_____
Former Dentist's Phone Number_____ Fax_____
Do you have problems with any of the following?

□Bad breath	□Clicking or popping of jaw	□Loose teeth or broken fillings
□Grinding teeth	□Periodontal treatment	□Food collection between teeth
□Bleeding gums	□Sores or growths in your mouth	□Sensitivity to hot
□Sensitivity to cold	□Sensitivity to sweets	□Sensitivity when biting

How often do you floss? _____ How often do you brush? _____
Has your medical physician instructed you to pre-medicate before dental procedures? _____

MEDICAL HISTORY

Physician's Name_____ Phone_____ Date of last visit_____
Have you ever had a serious neck injury? _____ Been hospitalized/had a major operation? _____
If yes, please describe_____
Please list any medications you are currently taking: Allergies:
_____ _____
_____ _____
_____ _____

Have you ever taken any of the group of drugs referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine), and Redux (dexfenfluramine). □ Yes □ No

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. □ Yes □ No

Are you on a special diet? □ Yes □ No Do you take blood thinners? □ Yes □ No

Do you use tobacco? □ Yes □ No Do you use controlled substances? □ Yes □ No

(Women) Are you pregnant? □ Yes □ No Nursing? □ Yes □ No Taking birth control pills? □ Yes □ No

AIDS/HIV Positive	□ Yes □ No	Cortisone Medication	□ Yes □ No	Hemophilia	□ Yes □ No	Radiation Treatments	□ Yes □ No
Alzheimer's Disease	□ Yes □ No	Diabetes	□ Yes □ No	Hepatitis A	□ Yes □ No	Recent Weight Loss	□ Yes □ No
Anaphylaxis	□ Yes □ No	Drug Addiction	□ Yes □ No	Hepatitis B or C	□ Yes □ No	Renal Dialysis	□ Yes □ No
Anemia	□ Yes □ No	Easily Winded	□ Yes □ No	Herpes	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Angina	□ Yes □ No	Emphysema	□ Yes □ No	High Blood Pressure	□ Yes □ No	Rheumatism	□ Yes □ No
Arthritis/Gout	□ Yes □ No	Epilepsy or Seizures	□ Yes □ No	High Cholesterol	□ Yes □ No	Scarlet Fever	□ Yes □ No
Artificial Heart Valve	□ Yes □ No	Excessive Bleeding	□ Yes □ No	Hives or Rash	□ Yes □ No	Shingles	□ Yes □ No
Artificial Joint	□ Yes □ No	Excessive Thirst	□ Yes □ No	Hypoglycemia	□ Yes □ No	Sickle Cell Disease	□ Yes □ No
Asthma	□ Yes □ No	Fainting Spells/Dizziness	□ Yes □ No	Irregular Heartbeat	□ Yes □ No	Sinus Trouble	□ Yes □ No
Blood Disease	□ Yes □ No	Frequent Cough	□ Yes □ No	Kidney Problems	□ Yes □ No	Spina Bifida	□ Yes □ No
Blood Transfusion	□ Yes □ No	Frequent Diarrhea	□ Yes □ No	Leukemia	□ Yes □ No	Stomach/Intestinal Disease	□ Yes □ No
Breathing Problems	□ Yes □ No	Frequent Headaches	□ Yes □ No	Liver Disease	□ Yes □ No	Stroke	□ Yes □ No
Bruise Easily	□ Yes □ No	Genital Herpes	□ Yes □ No	Low Blood Pressure	□ Yes □ No	Swelling of Limbs	□ Yes □ No
Cancer	□ Yes □ No	Glaucoma	□ Yes □ No	Lung Disease	□ Yes □ No	Thyroid Disease	□ Yes □ No
Chemotherapy	□ Yes □ No	Hay Fever	□ Yes □ No	Mitral Valve Prolapse	□ Yes □ No	Tonsillitis	□ Yes □ No
Chest Pains	□ Yes □ No	Heart Attack/Failure	□ Yes □ No	Osteoporosis	□ Yes □ No	Tuberculosis	□ Yes □ No
Cold Sores/Fever Blisters	□ Yes □ No	Heart Murmur	□ Yes □ No	Pain in Jaw Joints	□ Yes □ No	Tumors or Growths	□ Yes □ No
Congenital Heart Disorder	□ Yes □ No	Heart Pacemaker	□ Yes □ No	Parathyroid Disease	□ Yes □ No	Ulcers	□ Yes □ No
Convulsions	□ Yes □ No	Heart Trouble/Disease	□ Yes □ No	Psychiatric Care	□ Yes □ No	Veneral Disease	□ Yes □ No
						Yellow Jaundice	□ Yes □ No

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that if I, and/or my dependent(s), have insurance coverage, that all insurance benefits are assigned directly to my provider, 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.

Havasu and Parker Dental Center may use my health care information and may disclose such information to my insurance company and their agents (if applicable) for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end one year from the date signed below.

Signature of Patient/Responsible Party_____ **Date**_____

Print_____

Havasu Dental Center

Ilan H. Shamos, D.M.D. and Carlos R. Ruiz, D.D.S.

Office Policy

Patients with Dental Insurance: As a courtesy to you, our office will gladly submit to your insurance. We do NOT accept DMO or HMO plans. The estimated patient portion of your balance is due at the time of service. You are ultimately responsible for any unpaid claims after 60 days of nonpayment by your insurance company. Please keep in mind that we cannot estimate what your insurance will cover with insurance company. Please keep in mind that we cannot estimate what your insurance will cover with 100% certainty, you may have a balance after your claim is paid. In that event, a statement will be mailed to you.

Payments: We accept cash, checks, credit cards, and debit cards. We offer a 5% discount for cash patients if the account is paid in full at date of service. There will be a $30 charge for any returned checks. A delinquent billing charge of $30 plus interest at the rate of 1.5% will be assessed to all account balances that have not made payment arrangements within 60 days of billing statement being processed.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however that:

1. Not all services are covered benefits in all contracts. Some insurance arbitrarily select certain service they will cover.
2. All co-payments are due at the time of service. Deductibles, co-insurance, and co-pays are the responsibility of the patient/policy holder.
3. You are responsible for informing us of any changes in your insurance plan or policy. Failure to do so may result in denial of coverage, the fees for which you will be held responsible.
4. We do not bill third parties. Any court order between parents is a civil suit. The parent who brings the child is responsible for the charges.

Financing Options: No-interest payments are available through Care Credit. Care Credit is not affiliated with our office but we do accept their credit card for payment. If you are interested in learning more about Care Credit, ask one of our staff members and they will be happy to answer any of your questions and help you apply.

Broken and Missed Appointments: We request at least 48 hours' notice if you need to cancel your appointment for non-emergency reasons. We reserve the right to charge your account $50 if we are not notified at least 48 hours prior to your appointment. Thank you for assisting us in keeping our schedule full.

Military and Senior Citizens: Patients over the age of 65 and/or veterans without insurance will be offered a 5% discount if paying their account in full on the date of service.

By signing below, I verify that I completely understand, agree, and accept the policies outlined above and I understand the Havasu Dental Center reserves the right to update and make changes to the office policy at any time without prior notification.

Patient (or Guardian) Signature: _____ Date:_____

Havasu Dental Center

Dr. Ilan H. Shamos, D.M.D. and Dr. Carlos R. Ruiz, D.D.S.

Patient HIPAA Consent Form

Our notice of Privacy practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights and section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office. By signing this form, you consent to our use and disclosure of protected health information (PHI) about you for treatment, payment, and healthcare operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- The practice reserves the right to change the Notice of Privacy Policies.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.

I authorize that your office may contact me in the following manner (check all that apply):

HOME TELEPHONE:_(____)_____

- ☐ OK to leave detailed message on machine
- ☐ OK to leave message with call-back number only
- ☐ OK to leave message with family member (Who?_____)

WORK TELEPHONE:_(____)_____

- ☐ OK to leave detailed message on machine
- ☐ OK to leave message with call-back number only
- ☐ OK to leave message with family member (Who?_____)

CELLULAR TELEPHONE:_(____)_____

- ☐ OK to leave detailed message on machine
- ☐ OK to leave message with call-back number only

Signature:_____Date of Birth:_____Today's Date:_____

Witness:_____