## PATIENT INFORMATION

Last Name: ______________________________ First Name: ______________________MI: _____

Preferred Name: _____________________________________

Mailing Address: ___________________________________________________________________

City: _____________________State: _______ Zip:_______________

Date of Birth: __ /___ /_____ Age: ______ Employer/School: ___________________________

Gender: Male Female Social Security Number: ______ - _____ -__________

Marital Status: Single Married Widowed Separated Divorced

Home Phone: ____________________________ Cell Phone: _______________________________

Email: ______________________________________________________

Preferred method of contact: Text Email Phone Call

Who may we thank for referring you? __________________________________________________

**Emergency Contact Outside of Immediate Family:**

Name: _________________________________________________________

Phone Number: _____________________________ Relationship to Patient: ___________________________

### SPOUSE OR PARENT/GUARDIAN (if a minor) INFORMATION

☐ **Spouse** ☐ **Parent/Guardian**

Name: __________________________________________

Date of Birth: ___/___ /____ Social Security Number: ____ - ____ - ______

Address: ______________________________________________________________________________

Employer: _____________________________________________________________________________

Phone: _____________________________________________________________

If applicable:

Parent/Guardian Name: __________________________________________

Date of Birth: ___/___ /____ Social Security Number: ____ - ____ - ______

Address: ______________________________________________________________________________

Employer: _____________________________________________________________________________

Phone: _____________________________________________________________

### DENTAL INSURANCE INFORMATION

Primary Insurance: ___________________________________ Insurance Phone: ___________________________

Insurance is through: Self Spouse Mother Father Guardian

Subscriber Identification Number: ______________________________________________

Group Number: ______________________________________

Secondary Insurance: __________________________________ Insurance Phone:___________________________

Insurance is through: Self Spouse Mother Father Guardian

Subscriber Identification Number: __________________________________

Group Number: _______________________________

# MEDICAL HISTORY

PATIENT NAME: ____________________ BIRTH DATE: ____________________

Are you under a physician's care now? Yes No ____________________

Have you ever been hospitalized or had a major operation? Yes No ____________________

Have you ever had radiation treatment or injury to the head or neck? Yes No ____________________

Do you take, or have you taken, Phen-Fen or Redux ? Yes No ____________________

Are you on a special diet? Yes No ____________________ Do you use tobacco? Yes No ____________________

Are you taking any bone sparing Medications? Yes No Are you taking any blood thinners? Yes No

Do you use controlled substances? Yes No ____________________

Do you have any known drug allergies? Yes No

Do you have any allergies to the following?

Aspirin Penicillin Ibuprofen Codeine Acrylic Metal Latex Local Anesthetics Sulfa Other

If yes, please explain: ____________________

**WOMEN:** Are you pregnant /trying to get pregnant? Yes No Nursing? Yes No

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

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

Are you taking any medications, pills, or drugs? Yes No If yes, please list medications: ____________________

____________________

____________________

____________________

**To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.**

**SIGNATURE OF PATIENT, PARENT, or GUARDIAN** ____________________ **DATE:** ____________________

# Understanding Your Dental Insurance

Dental insurance is not meant to be a pay-all. It is only meant to help with the cost of your dental needs.

There are thousands of dental plans and policies. Each has individual riders and benefit levels. How much your policy covers has been pre-determined by your employer or the individual plan you purchased. It is impossible for us to guarantee your dental treatment will be covered by your individual plan. We do our best to present you with an estimation of what your insurance may pay. Your treatment plan has dental insurance codes and fees. We highly recommend you be proactive with your insurance company by calling their 800 number or visiting their website. Here you can find out if a procedure is covered and at what percentage prior to treatment.
You are responsible for services rendered whether it is a covered procedure according to your individual plan or not.

We are happy to send a pre-authorization request on your behalf to your dental insurance. Please be aware most pre-authorizations expire after 3 months. Pre-authorizations are guarantee by your insurance company to cover up to the limits of your plan. However, pre-authorizations are only for your expected course of treatment. Keep in mind that treatment can change during the procedure.

Some necessary routine dental services are not covered by dental insurance at all. We do not believe it is in your best interest to compromise your treatment in order to accommodate an insurance policy's restrictions that may provide you with a quality of care that is considerably less than you deserve. However, we are more than happy to discuss a treatment plan's advantages and disadvantages with you, alternative treatment plans if possible, and help you choose the type of treatment that is best for you.

The type of treatment we recommend is based on professional judgment, not whether you are covered by a dental benefit plan. We strongly feel that you, not your dental insurance company should choose the treatment best for you.

**I have thoroughly read and understand the above information. I understand that Tatum Highlands Dentistry can only provide an estimation of my patient portion, which is owed on the date of service. I understand that my insurance company determines the exact patient portion only after treatment has been completed and after the claim has been processed by my insurance company. I understand that I am responsible for the total cost of service if my insurance denies benefits.**

________________________________________ ____________________

**Patient/Guardian Signature** **Date**

# PATIENT CONSENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient’s Name: ______________________________________________

Signature: __________________________________________________

Relationship to Patient: ________________________________________

Date: ____________________

Tatum Highlands Dentistry
Angela C. Dotson DDS
26232 N Tatum Blvd #100
Phoenix, AZ 85050

**Cancellation Fee Policy**

Trying to accommodate every patient's individual needs and work schedule can be difficult. We work very diligently to stay on schedule to minimize your wait time in our office. A scheduled appointment time is a commitment we have to one another and it has to be reserved especially for you, our valued patient. When appointments are missed or canceled, that valuable time is lost. If you find that you are unable to keep your reserved appointment, ample notice will allow us to schedule another patient in need of treatment in your place.

**It is our office policy to apply one of the following charges to your account if we are given <u>less than 72 hours notice for a change of commitment</u>:**

**If your appointment is with the Hygienist a late cancellation or no-show within 24 hours notice $150 cancelation the day of appointment is the appointment fee of $250**

**If you are scheduled with the Doctor for Treatment a late cancellation or no-show will result in a percentage of the treatment you had scheduled for that days service.**

**+We have paid for a provider to be here for you so we hope that you understand the importance of that time to us.**

**+Hygiene patient may have co-pay due to out-of network day of treatment.**

**+If you have Delta Dental and Insurance payment goes to you, we will have you pay day of service for the Hygiene visit**

We are aware that that unforeseen circumstances occur, and we can appreciate that emergencies occasionally happen. All charges are subject to review by the owner of Tatum Highlands Dentistry and/or the office manager. If you have any questions regarding this or any other office policy or procedure, we are always more than happy to discuss them with you. Thank you in advance for your continued cooperation and understanding.

Patient Signature________________________________________ Date______________

Notice to Our Hygiene Patients With Insurance

We pride ourselves in being upfront and honest with our patients. With that being said, we would like to inform you that our office is considered **OUT OF NETWORK** with insurances. As a courtesy we still bill your insurance for any out of network benefits you may have, but our office fees and treatment options are not limited to the contracts of insurance.

It is our due diligence to bill all procedures completed to insurance using our office fees. Your hygiene claim may be higher than what is actually owed because Dr. Dotson offers a courtesy discount known as the **"hygiene loyalty adjustment"**.

*__New Patient__ We accept what insurance pays as a courtesy

*__Established Hygiene__ visits are discounted to **$250.**

*Any remaining balance not paid by your insurance is your financial responsibility.*

We appreciate having you in the office and will look forward to helping you with any of your dental needs.

**Effective as of August 1st 2024**

______________________________ ____________

**Signature** **Date**