Jeffrey D. Clark DDS, PC
8765 East Bell Road Suite 201
Scottsdale, Arizona 85260

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

GETTING TO KNOW YOU

Date

Last Name *First* *M.I.*

Prefers to be called by

Address

City *State* *Zip*

Home Phone *CELL Phone*

Date Of Birth	*Age*	*Male*	*Female*
Married	*Single*	*Divorced*	*Widowed*

Social Security #

If Student:

School *Grade*

If your child's last name and/or address are not the same as yours, please let us know

Email Address:

IS ANYONE IN YOUR FAMILY A PATIENT AT OUR OFFICE?

Name: *Relationship:*

Person To Contact For Emergency *Relationship*

Phone Number

Address

City *State* *Zip*

Closest Relative Not Living With You *Relationship*

Phone Number

Address

City *State* *Zip*

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE

Name

Relationship To Patient *Social Security Number*

Address

City *State* *Zip*

Home Number *CELL Number* *Email Address*

PERSON RESPONSIBLE FOR TREATMENT DECISIONS IF DIFFERENT

Name

Relationship To Patient

Address

City *State* *Zip*

Home Number *CELL Number* *Email Address*

DENTAL INSURANCE INFORMATION

Insurance Company

Insurance Address

Insurance Phone Number

Group Number

Insured's Employer Name

Insured's Name

Date Of Birth *Relation to Patient*

Insured's I.D. Number

Insured's Social Security No.

Please See Back

CONSENT FOR TREATMENT

1. ***I hereby authorize doctor or designated staff to take x-rays, study models, photograph, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient)_____'s dental needs and/or to be used for marketing purposes.***

2. ***Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.***

3. ***I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.***

4. ***I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.***

Patient's Signature_____Date_____Witness_____

Parent/Responsible Party's Signature_____

Relationship to Patient_____

DENTAL HISTORY

Patient Name	Medical Alert

Welcome! So that we may provide you with the best possible care,
Please complete both sides of this medical/dental history form.
All Information is completely confidential.

What is the reason for your visit today? _____

_____

DENTAL HISTORY

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____
How often do you have dental examination? _____
What was done at your last dental visit? _____
Was any treatment recommended to you that has not been completed? _____
Do you feel nervous about having dental treatment? Yes No
If so, what is your biggest concern? _____
Have you ever had an upsetting dental experience? Yes No
If yes, please describe _____
Have your parents experienced gum disease or tooth loss? Yes No

CURRENT DENTAL CONDITION

How often do you brush your teeth? _____How often do you floss? _____
What other dental aids do you use? (Sonicare, Waterpik, Superfloss, toothpick, etc.) _____
Do you have any dental problems now? Yes No
If yes, Please describe: _____
Please rate the present overall condition of your mouth **Poor** 1 2 3 4 5 6 7 8 9 10 **Excellent**
Rate the appearance of your smile. **Poor** 1 2 3 4 5 6 7 8 9 10 **Excellent**
Are you satisfied with your teeth's appearance? Yes No
Would you like a whiter smile? Yes No
Would you like straighter teeth? Yes No

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No

Have you noticed:

Mouth odors or bad tastes?	Yes	No
Bleeding or painful gums?	Yes	No
Frequent cold sores, blisters or any other oral lesions?	Yes	No
Your mouth is dry?	Yes	No
Loose teeth or change in your bite?	Yes	No
Clicking or popping of the jaw?	Yes	No
Food getting caught in between your teeth?	Yes	No
Pain (joint, ear, side of face)?	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Painful chewing on either side of the mouth?	Yes	No
Headaches, neck aches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
A burning sensation on your tongue?	Yes	No

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pins, fingernails)	Yes	No
Mouth breath while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Snore or have any other sleep disorders?	Yes	No
Smoke/chew tobacco or use other tobacco products?	Yes	No

Have you ever had:

An allergic reaction to Novocaine or local anesthetic?	Yes	No
Periodontal treatment?	Yes	No
Oral Surgery?	Yes	No
Orthodontic treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause_____
_____

Is there anything else about having dental treatment that you would like us to know? Yes No
If yes, please describe:

MEDICAL HISTORY

Patient Name	Medical Alert

1. Have you been under the care of a medical doctor during the past two years? ……...Yes No
   If yes, for what? _____
   Physician's Name _____ Phone _____
   Address _____ City _____ State _____ Zip _____

2. Have you taken any medication during the past two years? ……..……. Yes No

3. Are you taking any medication currently, including regular doses of aspirin or over the counter herbal medicines?..... Yes No
   If yes please list name and dosage: _____
   _____

4. Are you aware of having an allergic (or adverse) reaction to any medication or substance?…….. Yes No
   If yes, please list _____

5. Have you been a patient in the hospital during the past five years? ……Yes No

6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

AIDS/HIV	Yes	No	Epilepsy or Seizures	Yes	No	Nervous/Anxious	Yes	No
Allergies or Hives	Yes	No	Fainting or Dizzy Spells	Yes	No	Neurological Disorders	Yes	No
Anemia	Yes	No	Glaucoma	Yes	No	Osteoporosis	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Psychiatric/Psychological	Yes	No
Artificial Heart Valve	Yes	No	Headaches	Yes	No	Respiratory Disease	Yes	No
Artificial Joints (hip, knee)	Yes	No	Heart Issues	Yes	No	Rheumatic Fever	Yes	No
Asthma	Yes	No	Heart Pacemaker	Yes	No	Scarlet Fever	Yes	No
Bruise Easily	Yes	No	Heart Murmur	Yes	No	Skin Rash	Yes	No
Blood Transfusion	Yes	No	Hepatitis A B C (circle)	Yes	No	Sickle Cell Disease	Yes	No
Cancer/Tumors	Yes	No	Hemophilia	Yes	No	Sinus Trouble	Yes	No
Cancer Treatment	Yes	No	Herpes	Yes	No	Stroke	Yes	No
Chronic Cough	Yes	No	High Blood Pressure	Yes	No	Swollen Ankles	Yes	No
Cold Sores/Fever Blisters	Yes	No	High Cholesterol	Yes	No	Thyroid Problems	Yes	No
Congenital Heart Disease	Yes	No	Kidney Trouble	Yes	No	Tonsillitis	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Tuberculosis	Yes	No
Diabetes	Yes	No	Liver Disease	Yes	No	Ulcers/GERD	Yes	No
Diet (special/restricted)	Yes	No	Low Blood Pressure	Yes	No	Venereal Disease	Yes	No
Emphysema	Yes	No	Mitral Valve Prolapse	Yes	No	Yellow Jaundice	Yes	No

7. Do you have or have you had any disease condition or problem not listed?…… Yes No
   If yes, please list: _____

8. **Women:** Are pregnant or think you may be pregnant? Yes_____ Months No Nursing? Yes No

9. **Women:** Do you use birth control medications? …… Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who my release such information to you. I will notify the dentist of any changes in my health or medications.

Patient/Guardian Signature *Date*

History Review

Jeffrey D. Clark, DDS, PC
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Scottsdale, Arizona 85260
480 585 1853

How Did You Hear About Us?

So that we may improve patient services, could you please take a moment to tell us who we can thank for referring you to our office or how you heard about us?

Please check all that apply:

- ❒ Friend/Family Member_____
- ❒ Dentist/Specialist_____
- ❒ Website (Please Specify: Google, Social Media, Reviews)_____
- ❒ Magazine

  (Images, Scottsdale Airpark, Arizona Foothills, McDowell Mountain Ranch, North Valley)
- ❒ Post Card
- ❒ Driving By
- ❒ Work in our Building
- ❒ School Events
- ❒ Local Events
- ❒ Brochures delivered to your business
- ❒ Business Faire

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FINANCIAL POLICY

A) **Prepay Courtesy (Pre-Payment of Treatment in Full):**

A prepayment bookkeeping courtesy of **5%** will be subtracted for treatment that exceeds $100 of the total patient obligation if the patient pays in full at the first treatment visit. This courtesy requires that the patient **files and accepts their own insurance**, and payment must be made by **cash, check or money order only**.

B) **Dental Savings Plan:**

An annual membership is paid to the practice that will provide savings on dental treatment. The savings range from 15-50%. More information is available from our Financial Coordinator.

C) **Financing:**

For those patients wishing to extend payments over a longer period of time, financing can be arranged in our office. This line of credit is **up to 12 months, interest-free depending on the amounts**. There is **no prepayment penalty** and the process is simple and can usually be completed within 20 to 30 minutes.

Forms of Payment:

You may choose from any of the following (including any combination thereof) to pay in full or to pay your portion not paid by insurance or financing: Visa, MasterCard, American Express, Debit Card, Cash, Check, Money Order or the lines of credit referred to above.

INSURANCE

Our office understands the value of insurance benefits to our patients. We will gladly process and file your insurance at **no charge**. At the time of service, we will ask you only for your **estimated** portion. Please understand that this is only an **estimate**, and is based upon the information available to us. Benefits from most plans range between 50% and 80%. However, the insurance companies base the amount of benefit on a schedule of fees that are **arbitrarily** developed by the insurance companies. For this reason, **we may receive a lower payment than the estimate we have given you.**
The financial obligation for dental treatment is between you and our office. **The insurance company is responsible to you, and not to our office.** We will assist you in any way that we can, however, there are no guarantees and payment is due regardless of the benefits paid by your insurance.
Once your carrier has paid the claim, any difference will be due upon receipt of our statement. If for any reason, we have not received your insurance carrier's payment 60 days after the claim, the remaining balance will be due and payable by you, and possibly, subject to an 18% annual percentage rate interest charge.

In the event of default, legal interest on the indebtedness, collection cost (which could be as much as an additional 50%) and related attorneys' fees could also be added. In addition, a $10.00 fee will be added for all returned checks.

Finally, please notify us at least 48 hours in advance if you cannot make your appointment. We have set aside a considerable amount of time for your appointment and would like to offer it to someone else if possible. If we receive less than 48 hour notice or you do not make your appointment at all - ***THERE WILL BE A $50 CHARGE ON THE 3RD OCCURRENCE.***

I understand my financial options and obligations as described above. I am aware that 48 hour notice is required for any changes in scheduling. I am also aware that balances over 60 days will incur 18% APR finance charges. The treatment plan has been explained to me and I have agreed to the terms as listed.

_____ _____

Signature **Date**

Jeffrey D. Clark, DDS, PC
8765 East Bell Road, Suite 201
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480 585 1853
480 585 7695

Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

PATIENT NAME _____ **DATE** _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Jeffrey D. Clark, DDS, PC may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Jeffrey D. Clark, DDS, PC has a detailed document called the *'**Notice of Privacy Practices**'*. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, Jeffrey D. Clark, DDS, PC will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Jeffrey D. Clark, DDS, PC to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Jeffrey D. Clark, DDS, PC has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/Authorized Representative) _____ **DATE** _____

Relationship to Patient if signed by another party _____ **DATE** _____

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our *'Notice'* at any time by contacting:
Jeffrey D. Clark, DDS, PC
8765 East Bell Road, Suite 201
Scottsdale, Arizona 85260
480 585 1853

FORM Us