Welcome to Corona Dental

SECTION A — PATIENT INFORMATION

Date: ______________

Patient Name: ______________________________ ☐ Male ☐ Female
LAST FIRST MI

Address: ______________________________
STREET/P.O. CITY STATE ZIP

Phone: ______________________________
HOME WORK CELL

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed DOB: ______________ SS #: ______________

If patient is a minor please complete this section.

FATHER'S NAME: ______________________ Occupation: ______________________

Employer: ______________________ Work Phone: ______________________

Employer's Address: ______________________________

MOTHER'S NAME: ______________________ Occupation: ______________________

Employer: ______________________ Work Phone: ______________________

Employer's Address: ______________________________

SECTION B — HEALTH INFORMATION

Date of last dental visit: ______________ Reason for visit: ______________________

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies: ______________
☐ Allergy: Codeine
☐ Allergy: Penicillin
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
☐ *Due date:* ______________
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ OTHER: ______________

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Name of Physician: ______________________ Phone: ______________
- Do you have any health problems that need further clarifiiration? ☐ Yes ☐ No
  If yes, please explain: ______________________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____
Signature of patient, parent or guardian Date

SECTION C — PATIENT EMPLOYMENT INFORMATION

☐ NOT APPLICABLE

Occupation: ____________________ Employer: ____________________

Employer's Address: ____
STREET/CITY/STATE/ZIP PHONE

SECTION D — SPOUSE'S INFORMATION

☐ NOT APPLICABLE

Name: ____________________ ☐ Male ☐ Female DOB: __________ SS #: __________

Phone: ____
HOME WORK CELL

Occupation: ____________________ Employer: ____________________

Employer's Address: ____
STREET/CITY/STATE/ZIP PHONE

SECTION E — INSURANCE INFORMATION

☐ NOT APPLICABLE

PRIMARY:

Insurance Plan Name: ____________________ ID #: __________ Group # __________

Insurance Plan Address: ____
STREET/CITY/STATE/ZIP

Name of Insured: ____________________ DOB: __________ Is insured a patient? ☐ Yes ☐ No
LAST, FIRST, MI

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Address: ____
STREET/CITY/STATE/ZIP

Insured's Employer Name & Address: ____
STREET/CITY/STATE/ZIP

SECONDARY:

Insurance Plan Name: ____________________ ID #: __________ Group # __________

Insurance Plan Address: ____
STREET/CITY/STATE/ZIP

Name of Insured: ____________________ DOB: __________ Is insured a patient? ☐ Yes ☐ No
LAST, FIRST, MI

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Address: ____
STREET/CITY/STATE/ZIP

Insured's Employer Name & Address: ____
STREET/CITY/STATE/ZIP

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I grant my permission to you or your assignee, to telephone me at my home or at my work to discuss matters related to this form. The parent or guardian Is required to remain in the DENTAL OFFICE during their child's dental treatment. **I have read the above conditions of treatment and payment and agree to their content.**

____
Signature of patient, parent or guardian Date Relationship to patient

____
Signature of guarantor of payment/responsible party Date Relationship to patient

REFERRAL INFORMATION: Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative ☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other __________

Name of person or office that referred you: ____

<u>Corona Dental</u>

Dr. Michael Leavitt, DDS • Dr. David Dahl, DDS

55 E. Tallahassee Ave. • Corona de Tucson, AZ 85641

We appreciate you choosing Corona Dental for your dental needs. Our goal is to provide you with the best quality care possible. In doing so, we have established the following payment policy effective immediately.

Insurance Plans

We are contracted providers for many insurance companies. Please understand that not all types of services are covered under your plan benefits. You will be responsible for any amount left unpaid by your insurance. Please refer to your plan booklet for covered benefits.

For most other insurance companies we will gladly submit a claim on your behalf; however you will be responsible for your "estimated" portion due at the time of service. If we are not participating with your plan, please understand that we can only estimate what your portion due will be. You will be responsible for any amount left unpaid by your insurance.

Method of Payment accepted

Cash, Money order, Cashier's check, Visa, Mastercard, Dental Fee Plan through Care Credit Finance and personal checks. There is a $25.00 fee for all checks that are returned.

All payments are due at the time services are rendered. Any special financial arrangements must be made prior to your appointment time.

Failed Appointments

We require 24 hours notice for cancellation of appointments. If sufficient notice is not given, you will be charged a fee of $35.00.

Patient Signature: ______________________________

Date: ______________________________

Corona Dental

Patient Medication List

Patient Name: ______________________________ **Date:** __________________________

Patient Dob: __________________

Following is a list of medications I currently take:

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

I acknowledge that the preceding list of medications is true and complete.

__________________________________ __________________

Signature of Patient/Parent Guardian **Date**

Page _____ of ______

Phone: 520-762-0123 • Fax: 520-762-1100
55 E. Tallahassee Ave. • Corona de Tucson, AZ 85641

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: ________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

______________________________ Please ***print*** name of Patient

______________________________ Please ***sign*** for Patient / Guardian of Patient

______________________________ Legal Representative / Guardian

______________________________ Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: ______________________________

____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name Only ☐ Proper Surname ☐ Other ____________________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: ____________________ Relationship: ____________________

Name: ____________________ Relationship: ____________________

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

____
Signature of Privacy Officer

HIPAA made EASY™
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