

Welcome to Sierra Vista 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:

- | | | | | |
|--|---|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Allergies: _____ | <input type="checkbox"/> Cancer | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Stomach Problems |
| _____ | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergy: Codeine | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Allergy: Penicillin | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hepatitis | <i>Due date:</i> _____ | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> OTHER: _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Growths | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Rheumatism | _____ |

• 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 clarification? 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 APPLICABLEName: _____ 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/ZIPName of Insured: _____ DOB: _____ Is insured a patient? Yes No
LAST, FIRST, MI Patient's relationship to insured: Self Spouse Child OtherInsured's Address: _____
STREET/CITY/STATE/ZIPInsured's Employer Name & Address: _____
STREET/CITY/STATE/ZIP**SECONDARY:**

Insurance Plan Name: _____ ID #: _____ Group #: _____

Insurance Plan Address: _____
STREET/CITY/STATE/ZIPName of Insured: _____ DOB: _____ Is insured a patient? Yes No
LAST, FIRST, MI Patient's relationship to insured: Self Spouse Child OtherInsured's Address: _____
STREET/CITY/STATE/ZIPInsured'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: _____

Patient Acknowledgement of Privacy Practices

I give Sierra Vista Dental my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies and for health care operations like quality reviews.

I have been informed that I may review the practice Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Print Name _____ Date of Birth _____

Signature _____ Date _____

If signed by parent or legal Guardian, please state relationship to patient

Sierra Vista Dental

**Dr. Jared W. Haws & Dr. Michael A. Leavitt
Dr. David Dahl
4990 East Mediterranean Drive, Suite A
Sierra Vista, AZ 85635**

We appreciate you choosing Sierra Vista 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, Debit card, Dental Fee Plan through Care Credit

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

Failed Appointments

We require 48 hours notice for cancellation of appointments. If sufficient notice is not given, you may be charged a fee of \$35.

Patient Signature: _____

Date: _____