



754 S. Val Vista Drive, Suite 106, Gilbert, AZ 85296
Office: 480.539.7979 • Fax: 480.539.7977 • Website: smilesbygarza.com

Date: _____

Patient Information

Sex M F

Patient's Name _____

Address _____

City _____

State _____ Zip _____

Home # _____

Work # _____ Cell# _____

Date of Birth _____ Age _____

Social Security # _____

E-mail _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone (_____) _____

Spouse's Name _____

Spouse's Employer & Phone # _____

Whom may we thank for referring you? _____

IN CASE OF EMERGENCY CONTACT

Name _____

Phone (_____) _____

Relationship to Patient _____

**Please provide identification of responsible party and medical/dental insurance card.*

Primary Dental Insurance

Who is responsible for this account? _____ Policy Holder _____

Birth Date _____ SS# _____ Relation to patient: Spouse Partner Child

Employer _____ Employer Phone# _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____ ID# _____

Secondary Dental Insurance

Who is responsible for this account? _____ Policy Holder _____

Birth Date _____ SS# _____ Relation to patient: Spouse Partner Child

Employer _____ Employer Phone# _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____ ID# _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependents(s), have insurance coverage with _____ and assign directly to **Dr. John Garza** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges regardless of insurance coverage or whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

I consent the above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services. I agree to provide the necessary information needed in determining insurance benefits or the benefits payable for related services. I understand that payment is due at the time services are rendered and any estimated portion from treatment plans are estimates only and are estimated on information obtained by my dental insurance company.

X _____ Print Name _____
Signature Date

Over →

Dental and Health History

Reason for Today's visit? Questions or Concerns? _____

Have you been satisfied with dental care received in the past? Yes No _____

Would you like your teeth whiter? Yes No

Do you wear any removable dental appliances? (ei, dentures, partials, retainers) Yes No _____

Former Dentist _____ City/State _____

Date of Last dental visit _____ Date of last dental X-Rays _____

Physician's Name & Office Phone _____ Date of Last Visit _____

Additional comments or Concerns? _____

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

Place a Mark on "yes" or "no" to indicate if you have had any of the following:

- | | | | | | |
|-----------------------------|--|------------------------|--|--------------------------|--|
| AIDS?HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or Dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding abnormally | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Lesions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, persistent or bloody | <input type="checkbox"/> Yes <input type="checkbox"/> No | Infective Endocarditis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Depression | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you use Tobacco | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
- Cigars Cigarettes Pipe Chew

Women:
Are you pregnant? Yes No

Due Date _____

Birth control pills? Yes No

Are you nursing? Yes No

Allergies to the following? NONE

- | | | |
|----------------------------------|---|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Valium |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Nitrous Oxide |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Barbiturates(Sleeping Pills) |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Other Allergies | <input type="checkbox"/> _____ |

Medications

List any medications you are currently taking and the reason you take this drug or mark NONE.

Pharmacy Name _____

Phone (_____) _____ - _____

I certify that the information I have entered (personal, dental/medical history or insurance information) is to the best of my knowledge. I also certify and assume legal and financial responsibilities regardless of insurance coverage.

X _____ Print Name _____
Signature Date

PAYMENT POLICY AND AGREEMENT

IF YOU DO NOT HAVE DENTAL INSURANCE:

- **Payment is due at the time of services rendered, unless prior written arrangements have been made.**
- **No Checks please.** We accept Cash, Visa, MasterCard, American Express, Discover, Debit and Care Credit Cards.
- Financing is available through Care Credit.
- *If there is unpaid balance remaining on the account after a period of sixty days, we reserve the right to begin charging interest on your account at 1.8% of your unpaid balance per month. There will be a \$35.00 charge for all returned checks.

IF YOU HAVE DENTAL INSURANCE:

- Your insurance is a benefit to you. As a courtesy, we will be happy to assist you in sending forms and coordinating benefits. **However, if payment from the insurance company is not sufficient to pay the balance in full, the patient (and/or insured) is responsible for the remaining balance.** If upon receipt of payment from the insurance company, we find that there has been overpayment of \$50.00 or more, we will provide your account with a choice of a refund check or credit balance for that amount. This figure will vary by any deductible amount that has not yet been met.

WE do not accept Secondary Insurance

- Due to the numerous limitations placed by insurance companies regarding Coordination of Benefits on several policies. Your portion is due regardless of the secondary coverage. We will bill the secondary as a courtesy to you and have any additional payment sent to your home.
As personal account payments come in, we apply those payments to the head of the household, not the individual patient. The account balance is a "Family Running Balance" due, not an individual's balance due. We encourage you to read your "Explanations of Benefits" issued for payments from your insurance provider.

Divorced Parents:

- If the patients being seen are children from a divorced family, the parent who brings the child to the appointment is responsible for the **entire** payment of services. A receipt will be provided.

FAILED APPOINTMENTS:

- Failed appointments (less than 48 hours notice) are a significant contributor to rising healthcare costs. Individuals who fail an appointment time reserved for them may be assessed a fee based on the length of the missed appointment. Your appointment time has been reserved just for you. Please arrive ten minutes early, as it may be necessary to reschedule your appointment if you are late. We are committed to being prompt but need your help to stay on schedule. Thank You.
- We make every attempt to remind you of upcoming appointments, either by phone, postcard or e-mail and ask that you please respond back to confirm the appointment time and date.

Your signature indicates your acknowledgement of your responsibility for payment of fees and acceptance of the terms outlined as above.

Name of Patient

Name of Responsible Party

Signature

Date

Patient Consent

Payment is due as services are rendered. If I have dental insurance I agree to take care of any deductibles or co-payments **at each appointment.**

THE FORM OF PAYMENT IN OUR OFFICE IS DEBIT, CREDIT OR CASH ONLY.

Billing your insurance company is a service we provide as a courtesy to you. Our office will **ESTIMATE** your dental benefits as accurately as possible, but there may be clauses or restrictions that are unknown at this time.

We do not accept secondary insurance due to the numerous limitations placed by your insurance company regarding coordination of benefits. Your portion is due regardless of the secondary coverage. We will bill the secondary as a courtesy to you and have any additional payment sent to your home.

I do understand that it is ultimately my responsibility to know my insurance benefits. Any portion of my treatment not paid by my insurance company is my obligation and **I agree to pay the balance in full within 30 days of all claims being processed.** Any amount still outstanding after 30 days will result in late fee of \$15.00 per month charged to my account. If my account must be referred to small claims court or a collection agency, I agree to pay any court costs and collection fees of 66% in the fair prosecution of the claim.

In the future, if there are any changes in your health history or insurance it is your responsibility to inform this office.

THERE WILL BE A \$75.00 CANCELLATION FEE CHARGED FOR APPOINTMENTS CANCELLED WITHOUT 48 HOURS NOTICE.

IF 3 APPOINTMENTS ARE MISSED WITHOUT 24 HOURS NOTICE, THIS CAN RESULT IN DISMISSAL FROM THE PRACTICE.

Consent for Use of Records I hereby give my permission for the use of dental records, including photographs and radiographs, made in the process of examinations, treatment and retention for purposes of professional consultations, research, education, or publication in professional journals.

My signature certifies consent for dental treatment.

Name of Patient

Name of Responsible Party

Signature

Date

HIPAA FORM CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT:

Name: _____

Section B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting

Contact Person: Maureen, Office Manager
Telephone: 480-539-7979

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above.

Print Full Name Below:

_____, have had full opportunity to read and consider the contents of this consent form and your notice of privacy practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following below:

Personal Representative's Name Printed: _____

Relationship to the Patient: _____