POSPISIL DENTISTRY OF GILBERT
2730 S. VAL VISTA DR., # 106 GILBERT, AZ 85295
PHONE (480) 838-3305 • FAX (480) 838-3670

Patient Information

Name _____ Soc. Sec. # _____
Last Name First Name Middle Initial
□ Male □ Female Date of Birth _____ □ Child □ Single □ Married □ Widowed □ Divorced
*** If patient is under age 18, Responsible Party:**
Name _____
Last Name First Name Middle Initial
□ Male □ Female Date of Birth _____ □ Child □ Single □ Married □ Widowed □ Divorced

Contact Information

Address _____ Apt #_____
City_____ State_____ Zip_____
Home Ph. _____Work Ph. _____Cell Ph. _____
Email address: _____
*** Would you prefer to be text or emailed to confirm your dental appointments? □ Text □ Email □ Neither**
Patient's Employer_____Occupation_____
Name of friend/relative not living with you_____Relationship_____
Home Ph. _____ Work Ph. _____ Cell Ph. _____

Referral Information

Whom may we thank for referring you to our Office?
☐ Patient, Name_____ □ Location
☐ Doctor, Name_____ □ Other (Specify) _____

Primary Insurance

Name of Insured_____ Soc. Sec # _____
Last Name First Name Middle Initial
Relationship to Patient_____ Date of Birth _____
Address (If different From Patient) _____Apt #_____
City_____ State_____ Zip_____
Insured Employer_____Phone_____Occupation_____
Insurance Company Name_____ Phone _____
Address_____City_____State_____ Zip_____
Group # _____ Member ID Number (If Social Security # not used) _____

Additional Insurance

Name of Insured_____ Soc. Sec # _____
Last Name First Name Middle Initial
Relationship to Patient_____ Date of Birth _____
Address (If different From Patient) _____Apt #_____
City_____ State_____ Zip_____
Insured Employer_____Phone_____Occupation_____
Insurance Company Name_____ Phone _____
Address_____City_____State_____ Zip_____
Group # _____ Member ID Number (If Social Security # not used) _____

Authorization: (Please read and check each box)

☐ I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
☐ I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____Today's Date_____

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MEDICAL HISTORY

Patient Name_____
Physician's Name_____ Phone_____ Date of last visit_____
Have you had any serious illnesses or operations? ☐ Y ☐ N If yes, describe _____
_____
Are you currently under physician care? ☐ Y ☐ N If yes, Describe _____
WOMEN: Are you currently taking birth control pills? ☐ Y ☐ N
Are you pregnant? ☐ Y☐ N (If yes, circle trimester: 1st 2nd 3rd) If so are you nursing? ☐ Y ☐ N

CHECK YES OR NO WHETHER YOU HAVE HAD ANY OF THE FOLLOWING:

☐ Y ☐ N Anaphylaxis
☐ Y ☐ N Anemia
☐ Y ☐ N Arthritis, Rheumatism
☐ Y ☐ N Artificial heart valves
☐ Y ☐ N Artificial joints
☐ Y ☐ N Asthma
☐ Y ☐ N Back problems
☐ Y ☐ N Blood problems
☐ Y ☐ N Cancer
☐ Y ☐ N Chemotherapy
☐ Y ☐ N Circulatory problems
☐ Y ☐ N Cortisone treatments
☐ Y ☐ N Diabetes
☐ Y ☐ N Drug abuse
☐ Y ☐ N Epilepsy
☐ Y ☐ N Fainting
☐ Y ☐ N Food allergies
☐ Y ☐ N Glaucoma
☐ Y ☐ N Headaches
☐ Y ☐ N Heart attack
☐ Y ☐ N Heart murmur
☐ Y ☐ N Heart surgery
(if yes, describe _____)
☐ Y ☐ N Hemophilia / abnormal bleeding
☐ Y ☐ N Herpes
☐ Y ☐ N Hepatitis (Type _____)
☐ Y ☐ N High Blood Pressure
☐ Y ☐ N HIV+/Aids
☐ Y ☐ N Jaw pain
☐ Y ☐ N Kidney disease/malfunction
☐ Y ☐ N Liver disease
☐ Y ☐ N Mitral valve prolapse
☐ Y ☐ N MRSA
☐ Y ☐ N Nervous problems
☐ Y ☐ N Pacemaker
☐ Y ☐ N Pre-Med for Dental Work
☐ Y ☐ N Radiation treatment
☐ Y ☐ N Rapid weight gain or loss
☐ Y ☐ N Respiratory treatment
☐ Y ☐ N Respiratory disease (COPD)
☐ Y ☐ N Rheumatic/scarlet fever
☐ Y ☐ N Shortness of breath
☐ Y ☐ N Stroke
☐ Y ☐ N Surgical implant
☐ Y ☐ N Swelling of ankles/feet
☐ Y ☐ N Thyroid problems
☐ Y ☐ N Tobacco use
☐ Y ☐ N Tuberculosis (TB)
☐ Y ☐ N Ulcer/Colitis
☐ Y ☐ N Venereal disease
☐ Other _____
_____

Are you allergic to any of the following?

☐ Y ☐ N Aspirin
☐ Y ☐ N Codeine
☐ Y ☐ N Dental Anesthetics
☐ Y ☐ N Erythromycin
☐ Y ☐ N Latex
☐ Y ☐ N Penicillin
☐ Y ☐ N Sulfa Drugs
☐ Other _____

Please list any medications that you are currently taking?

_____
_____
_____
_____

ORAL BISPHOSPHONATE DRUGS (ACTONEL, BONIVA, FOSOMAX, ACTONOL…..)
Have you ever been treated with Bisphosphonate drugs: Yes_____ No_____ If you have been treated with Bisphosphonate drugs are you still currently using them?: Yes _____ No_____ Referring Doctor: _____

DENTAL HISTORY

What would you like us to do today? _____ Are you in dental discomfort today? ☐ Y ☐ N
Former Dentist _____ Phone number (if available) _____ Date of last dental visit _____
Have you ever experienced an adverse reaction during or in conjunction with a dental procedure? ☐ Y ☐ N

Check yes or no if you have had problems with any of the following:

☐ Y ☐ N Bad breath
☐ Y ☐ N Sensitivity to cold
☐ Y ☐ N Food collection between teeth
☐ Y ☐ N Bleeding gums
☐ Y ☐ N Sensitivity to hot
☐ Y ☐ N Grinding or clenching teeth
☐ Y ☐ N Loose teeth or broken fillings
☐ Y ☐ N Sensitivity to sweets
☐ Y ☐ N Sensitivity when biting

How many times a day do you brush? _____ Floss? _____
How do you feel about the appearance of your teeth? _____ Are you interested in whitening your teeth? ☐ Y ☐ N

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful treatment. If there is any change in my medical status, I will inform the dentist.

Signature _____ Date _____ Dr. Initial _____ Date _____

PLEASE DO NOT SIGN BELOW. THIS AREA IS RESERVED FOR FUTURE UPDATES.

I have read my medical history above and confirm that it states past and present medical conditions _____
Signature Date

I have read my medical history above and confirm that it states past and present medical conditions _____
Signature Date

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FINANCIAL AGREEMENT AND DENTAL INSURANCE

We are committed to providing you with the best possible care. In order to achieve this goal, we need assistance and understanding regarding our payment policy.

Payment for services is due at the time of services are rendered. We accept cash, check, and all major credit cards.

As a courtesy to you, we will process your insurance claims if you will provide a complete insurance form. You must realize however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Not all services are covered benefits in each contract. Some insurance companies arbitrarily select certain services that they will not cover. A few insurance carriers' reimbursement policies are based on an arbitrary "schedule" of fee for specified services. These fees bear no relationship to the current standard of cost for care in this area, and are absolute in their structure.
3. Some insurance companies do not pay for resin fillings (tooth-colored fillings) however, an alternate benefits is allowed, therefore you will be responsible for the difference in fees.
4. If your insurance company does not pay within 30 days, you will be responsible for the full balance. We will provide you with the necessary paper work for reimbursement.
5. Co-payments are due at the time services are rendered.
6. All Charges are your responsibility.
7. A $10.00 late fee will be added for all accounts over 60 days
8. Financial responsibility: I further agree to pay all finance charges, collection costs, attorney's fees, and any other costs that may be incurred to enforce collection of any amount outstanding.

If you have any questions about the above information, please do not hesitate to ask us. Thank you for your cooperation.

Patient signature: _____Date: _____

POSPISIL DENTISTRY OF GILBERT
2730 S. Val Vista Dr., STE 106
Gilbert, AZ 85295
(480)838-3305

To Our Patients:

We attempt to reach each of our scheduled patients to verify the date and time of the appointments so there will be no miscommunication on our part. In spite of our best efforts, we have occasional last minute cancellations and even "no-shows". When this happens it frustrates our effort to meet the needs of patients who would value that time.

We are requesting that patients understand and respect the need for a minimum of 24 hours advance notice of any appointment change in order that we would have adequate time to respond. If we do not receive adequate notification of intent to cancel, there will be a $50 failed appointment fee assessed to your account. Please understand this will not affect any patient who may become suddenly ill or suffer an emergency for which there was no time to respond.

It is our sincere expectation that your understanding will be sufficient to make this effort unnecessary. If you have any questions, please feel free to contact our office.

Sincerely,

Brent L. Pospisil, D.M.D.

Douglas S. Pospisil, D.M.D.

_____ _____

Patient Signature Date

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This Healthcare Practice recognizes that every patient has the Right of Privacy concerning their personal health information. We make every effort to protect and preserve patient records in a manner that secures this information.

By signing this Acknowledgement:
You are only confirming that you have received a copy of our PRIVACY PRACTICES.

You do not give up any of your Rights and you may choose at some point in the future to provide more specific instructions for us to follow regarding your personal health information.

I have received a copy of this office's Notice of Privacy Practices:

Print your name here: _____

Sign your name here: _____

Fill in today's date here: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PRIVATE HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU MAY ACCESS THIS INFORMATION

POSPISIL DENTISTRY OF GILBERT

Our Healthcare Practice takes patient privacy matters seriously. We work hard to meet and exceed all existing rules and regulations and will work to keep you informed regarding our office policies and your personal rights regarding privacy.

We are required by federal and state law to maintain the privacy of your health information. We are also required to give you this NOTICE about our privacy practices, our duties, and your right concerning your personal health information. We must follow the privacy practices described in this Notice while it is in effect. This Notice takes effect on April 14, 2003, and will remain in effect until we replace it, at which time we will issue a new Notice to Patients indicating a new activation date. You may request a copy of our Notice at any time, and may request additional copies, as needed by contacting our office.

How We Disclose Health Information

Specialist Referrals:
We use and disclose health information about your treatment within our practice, for general healthcare operations, and payment collection. That means your information is available to or immediate staff, and to other practitioners who we may refer you to for additional treatment. This includes, but is not limited to, other healthcare specialists such as surgeons, laboratories and the like. We will exercise our judgment in only distributing the minimum necessary information needed when sending health information to any outside Associates.

General Business Operations:
Your information may be reviewed in the course of general healthcare operations for activities such as conducting quality reviews, assessing practitioner performance, evaluation of business costs, conducting training programs, licensing accreditation, and certain certification activities, and other business related evaluations to help us in improving our delivery of healthcare to our patients.

Payment and Collection:
Your health information will be sent to third party payers for insurance collection and, when applicable, to collection agencies for assistance in receiving payment for services rendered. Additionally information may be used from time to time as necessary to secure payment for services. We will use our professional judgment and experience with common practice to make decisions on what information to disclose to secure payment.

Family, Friends, Personal Representatives and Others:
We may disclose your health information to a family member, friend, or other persons to the extent necessary to help with your healthcare or with payment for your healthcare. You may however request we not disclose to any other than yourself of which we will abide. An example where we might disclose to a family member or friend might be when someone drives you to the practice and we are reporting on progress and time remaining before completion, or where a family member desires to pick up a prescription or x-rays on your behalf. We will use our professional judgment and experience with common practice when disclosing your health information that it is directly relevant to the person's involvement in your healthcare. We may disclose health information to others who may be involved in your health care and are trying to ascertain your general condition, your current location, or learn of your death.

Marketing Health-Related Services:
We will not use your healthcare information for marketing communications without your written authorization. Under federal privacy rules we may send you updated information about our practice or healthcare system, send you information regarding programs and products we offer to further enhance your care and treatment, send reminder notices for appointments, and other small nominal gifts from time to time, such as tooth brushes, which is not considered marketing. We will never provide your name to an outside organization for marketing.

Our Business Associates:
We require all of our Business Associates to sign a contract specifying they too are strictly following patient privacy rules and regulations. We will act swiftly and decisively if we find any who violate provisions of their contract.

When the Law Requires Us to Disclose:
We may disclose your health information to government agencies or others, as required by law. Examples of this include, but are not limited to, law enforcement, required state agency reporting, or coroners seeking to confirm identity. Additionally we disclose to military authorities for purposes such as national security.

Abuse and Neglect:
We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or are the victim or possible other crimes. We disclose to the extent necessary to avert further harm to you or others.

PATIENT RIGHTS

Access to Records:
You have the right to look at copies of your health information, with limited exceptions. You may request photocopies and copies of x-rays. We will use the format you request, unless we are unable to practically do so. You must make your request to access for health information in writing to our practice. We can provide you with a form to do this, or you may do it by writing a letter specifying exactly what you want to view. If we provide photocopies we will charge you a set amount for each page copied. If you wish to receive x-ray duplicates, we will charge you a set fee per film copied. Check with the office for the current fee schedule. If you request an alternate format we will charge you per the expenses we incur to satisfy your request. You may prefer to ask for a summary rather than receive all of the pages in your file. We can prepare a summary depending on what you are seeking to obtain. The fee for summation will vary depending on time to compile. The hourly rate for summation is also on our current fee schedule.

We have up to 30 days (and sometimes longer) to respond, depending on what is required to meet your request. Specifics will be provided upon request.

List of Disclosures:
You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and a few other activities as specified by law, for the last six years, but not before April 14, 2003. If you request this list more than once in a 12 month period we will charge you a reasonable cost based fee for responding to the additional requests. Fees will be disclosed prior to action being taken.

Restrictions:
You have the right to place additional restrictions on our use or disclosure of your health information. We are not required to agree to these restrictions, however, if we do agree, we will abide by our agreement, except in certain emergency situations.

Communications to You:
You may request we communicate with you about your health information by alternative means or to alternative locations, when you make the request in writing. You must specify the alternative means or location provide satisfactory explanation how payments will be made under the alternative means or location.

Amendment of Your Records:
You have the right to request we amend your health information when requesting in writing. We may deny your request however, we will note in your records your request to amend and reason. We cannot delete anything from the formal record but we can add addendums to the record that may be able to meet your amendment request.

Electronic Notice of this Information:
If you received this information electronically (via email), you are entitled to receive this in written hard copy form.