FAMILY DENTISTRY, P.L.L.C.

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventative care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1 About Your Child

Name: _____ Date: _____

Nickname: _____ ☐ Male ☐ Female

Birthdate: ___ / ___ / ___ Age: ___

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous/Present Dentist: _____

Date of Last Visit: _____

Parent's Marital Status: ☐ Single ☐ Widowed ☐ Married ☐ Divorced ☐ Separated

2 Parent's Information

Mother's Information

(☐ Step Mother ☐ Guardian)

Name: _____

Wk#: _____ Ext: _____ Hm#: _____

Employer: _____ SS#: _____

Father's Information

(☐ Step Father ☐ Guardian)

Name: _____

Wk#: _____ Ext: _____ Hm#: _____

Employer: _____ SS#: _____

Who is responsible for making appointments

Name: _____

Phone #: _____

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

3 Account Info

Person Responsible for Account (if other than Parent)

Name: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Wk#: _____ Ext: _____ Hm#: _____

Employer: _____ SS#: _____

4 Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Tel #: _____

Group (Plan, Local or Policy) #: _____

Insured's Name: _____

Insured's Birthdate: ___ / ___ / ___ SS#: _____

Insured's Employer: _____

Insured's Name: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Tel #: _____

Group (Plan, Local or Policy) #: _____

Insured's Name: _____

Insured's Birthdate: ___ / ___ / ___ SS#: _____

Insured's Employer: _____

Insured's Name: _____

5 For Your Information

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

Broken appointments inconvenience many people. If you are unable to keep an appointment, please give us at least 24 hours notification so we can make that time available to someone else. Please understand this helps keep your dental fees down. Thank you.

OVER PLEASE

6 Medical History

Child's Physician: _____

Phone #: _____ Date of Last Visit: _____

Your child's current physical health is: ☐ Good ☐ Fair ☐ Poor

Is your child currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

_____

Is your child taking any prescription/over the counter drugs? ☐ Yes ☐ No

Please list each one: _____

_____

Does your child smoke or chew tobacco? ☐ Yes ☐ No

For Females: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Which Trimester? _____

Are you nursing? ☐ Yes ☐ No Due Date: _____

Have you ever had any of the following diseases or medical problems?

- ☐ Heart Attack/Stroke
- ☐ Angina
- ☐ Cancer/Chemotherapy
- ☐ Tumor/Growth
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ HIV+/AIDS
- ☐ Heart Surgery/Pacemaker
- ☐ Congenital Heart Defect
- ☐ Mitral Valve Prolapse
- ☐ Artificial Bones/Joints
- ☐ Artificial Valves
- ☐ Sinus Problems
- ☐ High/Low Blood Pressure
- ☐ Fever Blisters
- ☐ Severe/Frequent Headaches
- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ Epilepsy/Seizures/Fainting Spells
- ☐ Psychiatric Problems
- ☐ Tuberculosis (TB)
- ☐ Hepatitis
- ☐ Venereal Disease
- ☐ Hemophilia/Abnormal Bleeding
- ☐ Ulcers/Colitis
- ☐ Shingles
- ☐ Anemia/Radiation Treatment
- ☐ Asthma/Difficulty Breathing
- ☐ Emphysema
- ☐ Persistent Cough
- ☐ Arthritis
- ☐ Hospitalized For Any Reason
- ☐ Blood Transfusion
- ☐ Glaucoma

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

- ☐ Penicillin
- ☐ Erythromycin
- ☐ Cephalexin (Keflex)
- ☐ Tetracycline
- ☐ Dental Anesthetics
- ☐ Epinephrine
- ☐ Aspirin
- ☐ Codeine
- ☐ Valium
- ☐ Latex

Please list any other drugs that you are allergic to: _____

_____

7 Dental History

Reason For Visit

☐ Dental Cleaning ☐ Dental Examination ☐ Consultation Only

Describe present Dental problem: _____

_____

Best description of your child's past Dental Treatment record:

☐ This is first visit ☐ At least twice a year ☐ At least once a year

☐ About once every 2 or 3 years ☐ Only when there is a problem

Date of Last Dental Examination: _____

Date of Last Full Mouth X-Ray (Panoramic): _____

Has your child ever had a serious /difficult problem associated with any previous dental work? ☐ Yes ☐ No Explain: _____

_____

Does your child have any concerns or fears associated with Dental Treatment? _____

Does or has your child ever experienced pain/discomfort

In their jaw joint (TMJ/TMD)?	☐ Yes	☐ No	
Your child's current dental health is:	☐ Good	☐ Fair	☐ Poor
Do you like your child's smile?	☐ Yes	☐ No	
Does your child's gums ever bleed?	☐ Yes	☐ No	
Does your child brush their teeth daily?	☐ Yes	☐ No	
Does your child floss their teeth daily?	☐ Yes	☐ No	

Does or did your child ever have one of the following habits:

Thumb/Finger Sucking:	☐ Yes	☐ No
Lip Sucking/Biting:	☐ Yes	☐ No
Nail Biting:	☐ Yes	☐ No
Nursing Bottle Habits:	☐ Yes	☐ No

Does your child clench/grind their teeth? ☐ Yes ☐ No

8 Consent

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that my child may need during diagnosis and treatment. I understand where appropriate, credit bureau reports may be obtained.

_____

Signature Date

FOR OFFICE USE ONLY • FOR OFFICE USE ONLY • FOR OFFICE USE ONLY

UPDATE INITIALS					

NOTES:

All West Family Dentistry, P.L.L.C

Dr. Bradford M. Allen, D.D.S., P.C.

Dr. Charles E. Falk, D.D.S., P.C.

FINANCIAL RESPONSIBILITY AGREEMENT

We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our Financial Policy, which we require that you read, agree to, and sign prior to any treatment. We are pleased to discuss our professional fees with you at any time. Your clear understanding of the Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility upon arrival at your first appointment.

ADULT PATIENTS

Adult patients are responsible for full payment at time of services.

MINORS ACCOMPANIED BY AN ADULT

The adult accompanying a minor, his/her parents or guardians are responsible for full payment at time of service.

INSURANCE

We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer and your insurance company. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time. If you are paid by the insurance company instead of our practice, you then become responsible for the total account balance and payment would be expected immediately. We ask that you sign this form and/or any other necessary documents that may be required by your insurance company.

DEDUCTIBE/CO-PAYMENT

We ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, credit card or Patient Financing at the time we provide the service to you.

Signature: _____ Date: _____

Patient Name: _____

All West Family Dentistry, P.L.L.C

Dr. Bradford M. Allen, D.D.S., P.C.

Dr. Charles E. Falk, D.D.S., P.C.

CANCELLATION POLICY

We set aside dedicated time in our office for your dental appointment. We ask that you show our other patients and us consideration by calling at least 24 hours prior to your appointment if you are unable to attend. This allows us the time we initially reserved for you in our schedule to be filled by another patient who may have been waiting for this appointment time.

If you fail to give at least 24 hours' notice to cancel or change an appointment or fail to keep your appointment 3 times in one calendar year you will be dismissed from the practice. We do, however, understand that illness and emergencies occur and we do accommodate for those rare instances.

If you are unable to keep your appointment, please call our office at 623-412-9600 to reschedule.

I understand All West Family Dentistry's appointment cancellation policy and understand my responsibility to plan appointments accordingly and to notify their office appropriately if I have difficulty fulfilling my scheduled appointments.

Signature: _____ Date: _____

Patient Name: _____

ALL WEST FAMILY DENTISTRY, P.L.L.C.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable 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 legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect immediately and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclose of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or 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 the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to any authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, letters or text messages.)

PATIENT RIGHTS:

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, you may be charged for each page, and for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: 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 certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

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

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitle to receive this Notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Office Information:

Telephone: 623-412-9600 Fax: 623-412-9700

Email: front@allwestfamilydentistry.com

Address: 13470 N. 83rd Avenue, Suite #100 Peoria, AZ 85381

BRADFORD M. ALLEN, D.D.S., P.C.

CHARLES E. FALK, D.D.S., P.C.

FAMILY DENTISTRY, P.L.L.C.

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 able to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE ON THIS FORM WILL ALSO SERVE AS A RECORDS RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO ANOTHER DOCTOR/ FACILITY IN THE FUTURE.**

Printed Name: _____ Patient Signature: _____

Legal Representative: _____ Relation to Patient: _____

Email: _____

Please list any other parties who can have access to your health information. *This includes step-parents, grandparents, and any caretakers who can have access to this patient's records*:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize contact from this office to CONFIRM MY APPOINTMENTS, DISCUSS TREATMENT & BILLING via:

- ○ Cell Phone
- ○ Home Phone
- ○ Work Phone
- ○ Text Message
- ○ Email Message
- ○ Any of the above

Office Use Only

As a 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: _____