MITCHELL DENTAL
FAMILY AND COSMETIC DENTISTRY

(480) 947-4636
7500 East Angus Dr., Ste 2, Scottsdale, AZ 85251

Dental Registration and History

1. PATIENT INFORMATION

Patient Name _____
Last Name First Name Middle Initial

Date _____ Birthday _____

SS# or Insurance ID# _____ Sex ❑ M ❑ F

Address _____

City _____ State _____ Zip _____

Home Tel _____ Work Tel _____

Mobile # _____ Occupation _____

Email _____ Marital Status _____

Referral Source _____

Notes _____

2. EMPLOYER / SCHOOL

Employer/ School Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Email _____

Notes _____

3. EMERGENCY CONTACT

Emergency Contact Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Relationship _____

4. INSURANCE INFORMATION

Responsible Party Name _____

Relationship to Patient _____

Insurance Company _____

Subscriber Name _____

Group # _____ SS# _____

Birthday _____ Other Coverage ❑ Yes ❑ No

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with:

_____

and assigned directly to Dr. _____ all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named dentist may use my health care information and may disclose such information in the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan to completed or one year from the date signed below.

Signature _____ Date _____

5. DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____ Tel _____ Last X-Ray Date _____

Last Cleaning _____ Last Dental Visit _____

Do you feel pain ❑ Yes ❑ No if yes please describe _____

Do you feel numbness, swelling, or any other sensitivity? ❑ Yes ❑ No if yes please explain _____

_____

Additional comments about your past dental history _____

_____

Please Continue to 2nd Page

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6. HEALTH HISTORY

Physician Name _____ Physician Tel _____

Have you ever taken any of the group of drugs collectively referred to as "Fen-Phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentennlne), 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	❑ Yes ❑ No	Epilepsy	❑ Yes ❑ No	Radiation Treatment	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Fainting or dizziness	❑ Yes ❑ No	Respiratory Disease	❑ Yes ❑ No
Arthritis, Rheumatism	❑ Yes ❑ No	Glaucoma	❑ Yes ❑ No	Rheumatic Fever	❑ Yes ❑ No
Artificial Heart Valves	❑ Yes ❑ No	Headaches	❑ Yes ❑ No	Scarlet Fever	❑ Yes ❑ No
Artificial Joints	❑ Yes ❑ No	Heart Murmur	❑ Yes ❑ No	Shortness of Breath	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Heart Problems	❑ ❑ No	Sinus Trouble	❑ Yes ❑ No
Back Problems	❑ Yes ❑ No	Hepatitis Type __	❑ Yes ❑ No	Skin Rash	❑ Yes ❑ No
Bleeding abnormally, with extractions or surgery	❑ Yes ❑ No	Herpes	❑ Yes ❑ No	Special Diet	❑ Yes ❑ No
Blood Disease	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Jaundice	❑ Yes ❑ No	Swollen Feet or Ankles	❑ Yes ❑ No
Chemical Dependency	❑ Yes ❑ No	Jaw Pain	❑ Yes ❑ No	Swollen Neck Glands	❑ Yes ❑ No
Chemotherapy	❑ Yes ❑ No	Kidney Disease	❑ Yes ❑ No	Thyroid Problems	❑ Yes ❑ No
Circulatory Problems	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No	Tonsillitis	❑ Yes ❑ No
Congenital Heart Lesions	❑ Yes ❑ No	Low Blood Pressure	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Cortisone Treatments	❑ Yes ❑ No	Mitral Valve Prolapse	❑ Yes ❑ No	Tumor or growth on head or neck	❑ Yes ❑ No
Cough, persistent or bloody	❑ Yes ❑ No	Nervous Problems	❑ Yes ❑ No	Ulcer	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Pacemaker	❑ Yes ❑ No	Venereal Disease	❑ Yes ❑ No
Emphysema	❑ Yes ❑ No	Psychiatric Care	❑ Yes ❑ No	Weight Loss, unexplained	❑ Yes ❑ No
		Do you wear contact lenses?	❑ Yes ❑ No		

Women: Are you pregnant? ❑ Yes ❑ No If yes due date: _____ Are you nursing? ❑ Yes ❑ No

7. MEDICATION & ALLERGIES

Please list all the medication you are currently taking _____

_____

_____

_____

_____

Are you allergic to any of the following? ❑ Yes ❑ No

If yes please circle: Aspirin, Barbiturates (Sleeping pills), Codeine, Iodine, Latex, Local Anesthetic, Penicillin

Any other allergies? ❑ Yes ❑ No

8. UPDATES (for future visits)

Date _____

Changes to medical history _____

_____

Patient Signature _____

Doctor Signature _____

Date _____

Changes to medical history _____

_____

Patient Signature _____

Doctor Signature _____

Patient Signature _____ Date _____

Doctor Signature _____ Date _____

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PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date:_____

Print Patient Name: _____

Signature: _____

Relationship to Patient: _____

Mitchell Dental
7500 E Angus Dr, Suite 2
Scottsdale, AZ 85251

January 30, 2014 AM

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Financial Policy

Thank you for choosing our office for your dental healthcare. We are unconditionally committed to provide you with the best in preventative approaches as well as the highest standards of treatment and dental procedures for solutions to your dental problems.

Our office does require your social security number for our records. Please understand that other than your insurance company (if applicable) all of your patient information is strictly confidential. To have your services comfortably affordable please review the following financial policies and select the type of account that best suits your needs:

Payment is expected on the day services are rendered (initials____)
We accept Visa, MasterCard, Discover, and American Express.

Care Credit Financing Available (initials____)
Our patient coordinator will be happy to assist you with the application process.

Understanding Insurance Benefits
As a courtesy for our patients with most dental insurance plans, we will happily submit dental claims to your insurance company for services rendered. Insurance companies are by Arizona regulations to pay your claims within 30 days of having been submitted. The estimated portion of your non-covered expenses will be due at the time of services. **Please be advised that your estimated out of pocket portion is only an approximation, we can never guarantee what an insurance company will and will not cover.** Since your contract is between you and your insurance company, any balance not paid in 45 days will be your responsibility. We will do everything possible to insure that the insurance company pays for any and all eligible expenses. By you signing this policy, you are giving us permission to bill your insurance company for services rendered and allow us to review your treatment plan with them. You understand completely that if your insurance company does not cover said services, for any reason, you are **FULLY** responsible.
Our patient coordinator is very knowledgeable in all areas of our financial policy and will be more than happy to assist you with solutions to your financial needs.

We do expect you to show up for your scheduled apportionments. If you do need to reschedule, we require 48 hours notice. If this notice is not given, or an appointment is just missed you may be assessed a **$50.00 missed appointment charge**.

Signature_____ Date_____

April 20, 2017 updated