

**Welcome to Gentle Dentistry  
Please Tell Us About Yourself**

**Christopher C. Bishop**  
D.D.S., P.C.

2150 E. Brown Rd., Ste. 4  
Mesa, Arizona 85213  
phone 480.969.8888  
fax 480.649.9048  
www.gentledentistrymesa.com

Name: \_\_\_\_\_  
Last First MI Title

Preferred Name: \_\_\_\_\_ Male Female

Address: \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Separated  Domestic Partner

How did you hear about our office? \_\_\_\_\_

Do you prefer to be contacted for appointment confirmation via e-mail or phone? *(Please circle preference)*

**Insurance - Primary**

Subscriber Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Subscriber SN/ID: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

Subscriber Employer: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Insurance Company Phone: \_\_\_\_\_ Group Number: \_\_\_\_\_

**Insurance - Secondary**

Subscriber Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Subscriber SN/ID: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

Subscriber Employer: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Insurance Company Phone: \_\_\_\_\_ Group Number: \_\_\_\_\_

**Assignment and Release**

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Gentle Dentistry 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 hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

**Responsible Party Signature:**

Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

## Medical History

Do you have a personal physician?  Yes  No

Physicians Name: \_\_\_\_\_

Physicians Phone: \_\_\_\_\_

Date of last visit: \_\_\_\_\_

Your current physical health is:  Good  Fair  Poor

Are you currently under the care of a physician?  Yes  No

Please explain: \_\_\_\_\_

Do you use tobacco in any form?  Yes  No

Have you had any metal rods, pins or implants placed?  Yes  No

Are you taking any medications?  Yes  No

Please list each one: \_\_\_\_\_

Have you ever had any surgical procedures?  Yes  No

Please list each one: \_\_\_\_\_

- | Yes                      | No                       | <b>Conditions</b>       |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Bleeding       |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol Abuse           |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies               |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina Pectoris         |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis               |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Heart Valve  |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Transfusion       |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy            |
| <input type="checkbox"/> | <input type="checkbox"/> | Colitis                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Congenital Heart Defect |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Breathing    |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug Abuse              |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema               |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy                |
| <input type="checkbox"/> | <input type="checkbox"/> | Facial Surgery          |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting Spells         |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever Blisters          |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Headaches      |

- | Yes                      | No                       | <b>Conditions</b>            |
|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma                     |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV+AIDS                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Surgery                |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis C                  |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure          |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement            |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems              |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease                |
| <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure           |
| <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse        |
| <input type="checkbox"/> | <input type="checkbox"/> | Pace Maker                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Problems         |
| <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy            |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever              |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Shingles                     |

- | Yes                      | No                       | <b>Conditions</b>   |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus Problems      |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke              |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problems    |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis        |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcers              |

- | Yes                      | No                       | <b>Allergies</b>   |
|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Aspirin            |
| <input type="checkbox"/> | <input type="checkbox"/> | Codeine            |
| <input type="checkbox"/> | <input type="checkbox"/> | Dental Anesthetics |
| <input type="checkbox"/> | <input type="checkbox"/> | Erythromycin       |
| <input type="checkbox"/> | <input type="checkbox"/> | Jewelry            |
| <input type="checkbox"/> | <input type="checkbox"/> | Latex              |
| <input type="checkbox"/> | <input type="checkbox"/> | Metals             |
| <input type="checkbox"/> | <input type="checkbox"/> | Penicillin         |
| <input type="checkbox"/> | <input type="checkbox"/> | Tetracycline       |

- | Yes                      | No                       | <b>If Female, Please Answer</b>              |
|--------------------------|--------------------------|----------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Are you taking Birth Control Pills?          |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant?<br>If so, # of weeks _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you nursing?                             |

Nearest relative not living with you:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

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 medical status.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Dental History

How may we help you today? \_\_\_\_\_

Your current dental health is:  Good  Fair  Poor

Do you require antibiotics before dental treatment?  Yes  No

Are you currently in pain?  Yes  No

Have you ever had gum treatment?  Yes  No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ)  Yes  No

Are you under stress? (new job, moving, relationships)  Yes  No

Do you like your smile?  Yes  No

Is there anything you would like to change about your smile?  Yes  No

Are you happy with the color of your teeth?  Yes  No

Do your gums bleed?  Yes  No

How many times a do you: floss/week? \_\_\_\_\_ brush/day? \_\_\_\_\_

Are your teeth sensitive to heat, cold or anything else?  Yes  No

Have you lost any teeth?  Yes  No

Have you ever had a serious/difficult problem with any previous dental work?  Yes  No

Have you ever had any unfavorable dental experience?  Yes  No

When was your last dental cleaning? \_\_\_\_\_

When was your last dental visit? \_\_\_\_\_

Why did you leave your previous dentist? \_\_\_\_\_

How can we accommodate you better during your dental visit? \_\_\_\_\_

We offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services

below you would like our friendly staff to discuss with you during your visit.

- |                                     |                    |                |
|-------------------------------------|--------------------|----------------|
| Sapphire Tooth Whitening            | Veneers/ Lumineers | Invisalign     |
| Traditional Orthodontics (Brackets) | Smile Makeover     | Bonding        |
| Sealants                            | Crown and Bridge   | Implant Crowns |
| Partials/Dentures                   | Night/Sport Guards |                |

## Insurance and Financial Policy

We believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know:

Initial

\_\_\_\_\_ Your dental benefits are based upon contract made between your employer and an insurance company. If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.

\_\_\_\_\_ We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment but will give you the exact out of pocket figures you may require.

\_\_\_\_\_ We will bill your insurance as a courtesy. If Insurance does not pay within 90 days, we reserve the right to request payment in full for service from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

\_\_\_\_\_ We require in full for your portion at the time of service. We accept MasterCard, Visa, American Express, Discover, cash, and checks (for existing patients with established payment history). If you are in need of an extended finance option, we also work with CareCredit, who offers 3, 6 or 12 months "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit.

\_\_\_\_\_ A specific amount of time is reserved especially for you and we strongly encourage will patients to keep their appointments. If you must change your appointment, we require at least 24 hour notice to avoid a \$35/hour cancellation fee (emergencies are an exception).

\_\_\_\_\_ In the event of an emergency after regular business hours a \$55 emergency fee will be charged for established patients in addition to the necessary treatment fees. Patients who are not established in the practice will be charged \$125 after hours emergency fee.

I agree with the above conditions.

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient/parent Signature: \_\_\_\_\_

## **NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical and dental records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse Protected Health Information (PHI).

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

### **Uses and Disclosures of Protected Health Information**

Your Protected Health Information may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing dental health care services to you, to pay your dental health care bills, to support the operation of the dental practice, and any other use required by law.

**Treatment:** We will use and disclose your Protected Health Information to provide, coordinate, or manage your dental health care and any related services. This includes the coordination or management of your dental health care with a third party. For example, your protected health information may be provided to a dentist or physician to whom you have been referred to ensure that the health care professional has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, and conducting or arranging for other business activities. We may use or disclose, as needed, your protected health information to support the business activities of this practice. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your dentist. We may also call you by name in the waiting room when your dentist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may call your home and leave a message (either on an answering machine or with the person answering the phone) to remind you of an upcoming appointment, the need to schedule a new appointment or to call our office. We may also mail a postcard reminder to your home address. If you would prefer that we call or contact you at another telephone number or location, please let us know.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of HIPAA.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

### **Your Rights**

The Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes described in this Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply.

Your dentist is not required to agree to a restriction you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept this Notice alternatively (i.e. electronically).

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this Notice and will inform you of any changes. You then have the right to object or withdraw as provided in this Notice.

### **Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint at our office and main telephone number. We will not retaliate against you for filing a complaint.

This Notice was published and becomes effective on/or before 1/15/2008.

GENTLE Family Dentistry  
2150 E. Brown Rd. #4  
Mesa, AZ 85213  
480-969-8888

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

### Section A: Patient Giving Consent

Name \_\_\_\_\_

Address \_\_\_\_\_

### Section B: To The Patient - Please Read The Following Statement 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. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. 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:

GENTLE Family Dentistry  
2150 E. Brown Road, Suite 4, Mesa, Arizona 85207  
Telephone (480) 969-8888 • Fax (480) 649-9048

**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 GENTLE Family Dentistry as listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

### SIGNATURE

I, \_\_\_\_\_, 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 being signed by a personal representative on behalf of the patient please complete the following:

Personal Representative's Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

### YOU ARE ENTITLED TO A Copy OF THIS CONSENT AFTER YOU SIGN IT.

**REVOCAION OF CONSENT:** I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations .

I understand that revocation of my Consent will not effect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after 1 have revoked my Consent.

Signature \_\_\_\_\_ Date \_\_\_\_\_