McDowell Dentistry of Goodyear

New patients

Welcome to our practice. Our primary purpose is to serve you and your family, to provide for your dental health needs in a considerate and caring fashion. For your protection this office has the most modern equipment, the latest techniques, above all, we follow OSHA guidelines in advanced sterilization technology for both staff and patient protection.

Consent for Services

As a Condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, and any dental services performed without previous financial arrangements, must be paid for in full at time services are preformed. I understand that the fee estimate listed for this dental care can only be extended for a period of **six** months from the date of the patient examination.

(Initials)_____

Medical and Dental Authorization

I have read the information on the health questionnaire and it is accurate to the best of my knowledge. I understand that the dentist to help determine appropriate and helpful dental treatment will use this information provided. If there are any changes in my medical status, I will inform the dentist.

(Initials)_____

Insurance Authorization

If you have dental insurance, we will gladly process your forms. However, we request that you pay your **estimated** portion when services are rendered. **Please remember that our contract for payment is with you and not your insurance carrier.** We are happy to bill your insurance as a courtesy to you, when you have provided us with your complete insurance information. We allow 45 days from the date of service for payment from an insurance company. After this period, we ask you to become responsible for payment of all unpaid fees.

(Initials)_____

Payment Options

Payment is due at the time of treatment. We accept cash, check, and all major credit cards. We also have two no interest payment plans, Care Credit and All Care, that allows you to start treatment today and spread payments over time. Applying for Care Credit and All Care only takes a few minutes and there is no fee to apply.

(Initials)_____

Caregiver other than Parent/Guardian

(For patients under 18 years old only)

I am giving the following adults permission to bring my child to their dental appointment's. I understand that only myself and those listed below will have the authority to authorize treatment. I understand that any person bringing the patient in for treatment not listed above must have a letter of consent from me or treatment could be refused or delayed. This authorization will remain in effect unless designated in writing that such consent for treatment of minor is cancelled. I will notify McDowell Dentistry of any changes.

_____

NAME (AUTHORIZED CAREGIVER(S) PHONE RELATIONSHIP TO PATIENT

_____

NAME (AUTHORIZED CAREGIVER(S) PHONE RELATIONSHIP TO PATIENT

(Initials)_____

I HAVE READ THE ABOVE OFFICE POLICIES AND CONDITIONS OF TREATMENT AND AGREE TO THEIR CONTENT.

_____Date_____

Signature of patient, parent or guardian

PATIENT INFORMATION

Name_____ Birth date_____ SS#_____

Address_____ City_____ State _____ Zip_____

Sex _____M _____F ____Married_____Widowed____Minor____Single____Divorced

E-mail _____ Do we have your permission to email you our news letter ***YES / NO***

Home Phone _____Cell Phone _____

Employer/School _____Employer/School Phone _____

Employer/School Address_____City _____ State ____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____Phone _____

I give_____ permission for McDowell Dentistry to communicate with them regarding my Dental treatment or any question regarding billing, and/or my appointments

Responsible Party

Name of Person
Responsible for this Account _____Relation to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthday_____

Employer _____ Work Phone _____

Insurance Information

Name of Insured _____ Relation to Patient _____

Birthday _____ Social Security # _____Date Employed _____

Employer _____ Work Phone _____

Employer Address _____City _____State _____Zip _____

Insurance Company _____Group #_____

Address _____City _____ State _____ Zip _____

Insurance ID# _____ Insurance Phone _____

Additional Insurance Information

Name of Insured _____ Relation to Patient _____

Birthday _____ Social Security # _____Date Employed _____

Employer _____ Work Phone _____

Employer Address _____City _____State _____Zip _____

Insurance Company _____Group #_____

Address _____City _____ State _____ Zip _____

Insurance ID# _____ Insurance Phone _____

Dental History

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Check if you have had problems with any of the following:

___ Bad Breath	___ Grinding Teeth	___ Sensitivity to hot
___ Bleeding gums	___ Loose teeth or broken fillings	___ Sensitivity to sweets
___ Clicking or popping jaw	___ Periodontal treatment	___ Sensitivity when biting
___ Food Collection between the teeth	___ Sensitivity to cold	___ Sores or growths in your mouth

___History of Periodontal treatment (Deep cleaning)

How often do you floss? _____ How often do you brush? _____

Medical History

Physician's Name _____ Date of last visit _____

Physician's Number _____

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 phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). _____ Yes _____No

Have you had any serious illnesses or operations? _____ Yes _____No If yes, describe _____

Have you ever had a blood transfusion? _____ Yes _____No If yes, give approximate dates _____

(Women) Are you pregnant? _____ Yes _____No Nursing? ____ Yes ____No Taking birth control pills?_____ Yes _____No

Have you had any of the following: please circle

Anemia	Congenital Heart Lesions	Hepatitis	Scarlet Fever
Arthritis, Rheumatism	Cortisone Treatments	Hernia Repair	Shortness of Breath
Artificial Joints	Cough, Persistent	High Blood Pressure	Skin Rash
Artificial Heart Valves	Cough up Blood	HIV/AIDS	Stroke
Asthma	Diabetes	Jaw Pain	Swelling of Feet or Ankles
Back Problems	Epilepsy	Kidney Disease	Thyroid Problems
Bleeding Abnormally	Fainting	Liver Disease	Tobacco Habit
Blood Disease	Glaucoma	Mitral Valve Prolapse	Tonsillitis
Cancer	Headaches	Pacemaker	Tuberculosis
Chemical Dependency	Heart Murmur	Radiation Treatment	Ulcer
Chemotherapy	Heart Problems	Respiratory Disease	Venereal Disease
Circulatory Problems	Hemophilia	Rheumatic Fever	

List medications you are currently taking and the correlating diagnosis: Allergies:

_____ _____

_____ _____

_____ _____

Authorization and Release

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have change in health. I certify that I, and/or my dependent(s), have insurance coverage with _____ assign directly to **McDowell 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 authorize the use of my signature on all insurance submissions. The above-named facility may use my health care information to 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 the current treatment plan is completed or one year from the date signed below.

_____ _____ _____

Signature of Patient, Parent, Guardian or Personal Representative Print Patient Name Date

*** Important Medical Alert ***

A connection between **Fosamax**, and other bisphosphonates, with a serious bone disease called Osteonecrosis of the jaw (ONJ) has been found.

Bisphosphonates are commonly used in tablet form to **prevent and treat osteoporosis** in postmenopausal women. They are also used in the treatment of **Paget's disease.** Stronger forms given orally or intravenously (IV) are commonly used in the **management of advanced cancers** including, but not limited to, lung cancer, breast cancer, prostate cancer, multiple myeloma, and other masatic cancers.

Have you ever taken any of the following bisphosphonates?

Y N Alendronate (Fosamax)
Y N Clodronate (Bonefos, Ostac)
Y N Etidronate (Didronel)
Y N Ibandronate (Boniva)
Y N Pamidonate (Aredia)
Y N Raloxifene (Evista)
Y N Risedronate (Actonel)
Y N Terparatide (Foreto)
Y N Tiludronate (Skelid)
Y N Zoledronate (Zometa)

If yes, when? _____

_____

_____

_____

Prescribing Doctor: _____ _____

Name Phone

_____

Patient or Responsible Party Name

_____ _____

Patient or Responsible Party Signature Date

NOTICE OF PRIVACY PRACTICES

McDowell Dentistry
14122 McDowell Road Suite 200
Goodyear, Arizona 85388

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.

Our commitment here at McDowell Dentistry is to serve our patients with professionalism and caring, being sure at all times to PROTECT the privacy and security of all Protected Health Information.

During the course of serving your interests, it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where information may be shared:

- **During treatment, we may find it necessary to consult with a dental laboratory.**
- **For payment purposes, we may use the services of a billing service.**

During dental care, we may need to consult with your physician or previous dentist.

- **For payment purposes, we need to supply information requested from your dental insurances company.**

We here at McDowell Dentistry are committed to obeying all Federal, State, and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. The individual, as provided by law, may revoke this written authorization at any time.

If you have any questions or comments regarding your Protected Health Information, feel free to contact our Compliance Officer:

I have read and understand the above Notice of Privacy Practices.

Signed: _____ Date: _____/_____/_____
(Patient or Legal Guardian)

McDowell Dentistry

Cancellation Policy

YOUR DENTAL APPOINTMENT HAS BEEN RESERVED ESPECIALLY FOR YOU.

THE OFFICE MANAGER WILL CALL THE DAY BEFORE YOUR SCHEDULED APPOINTMENT TO CONFIRM THE TIME SET FOR YOU.

IF YOU NEED TO CANCEL YOUR APPOINTMENT FOR ANY REASON, KINDLY GIVE US **24 HOURS NOTICE**, OR A **$40.00 CANCELLATION FEE** WILL BE CHARGED TO YOUR ACCOUNT.

THANK YOU FOR HELPING US PROVIDE QUALITY DENTAL CARE, BY RESPECTING THE APPOINTMENT TIME SET FOR YOU.

_____ _____/_____/_____

Signature Date