

Judy H. Huey D.D.S

9522 E. San Salvador Dr., #315 • Scottsdale, AZ 85258 • 480-767-0132 • office@judyhueydds.com

Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

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

{Please Print Name}

{Signature}

{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

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Date _____

Patient Name _____ Preferred Name (if different) _____

Address _____

City _____ Zip _____

Telephone: home _____ work _____ cell _____

E-mail address _____ Employer _____

Occupation _____ S.S # _____ Date of birth _____

Spouse's/Parent's name _____

Address (if different) _____

Occupation _____ Employer _____

Do you have dental insurance? **Yes No** Insurance company _____
Group# _____ ID# _____

Named of insured person _____ SS# of insured person _____

Date of birth of insured person _____

Who recommended you to us? _____

HEALTH HISTORY

I. CIRCLE APPROPRIATE ANSWER (leave BLANK if you do not understand the question): -----

- Yes No Is your general health good?
Yes No Has there been a change in health within the last year?
Yes No Have you been hospitalized or had a serious illness in the last three years?
Why? _____
Yes No Are you being treated by a physician now?
For what? _____
Date of last medical exam _____

II. HAVE YOU EXPERIENCED? -----

- | | | | | | |
|-----|----|------------------------|-----|----|--|
| Yes | No | Chest pain (angina)? | Yes | No | Seizures? |
| Yes | No | Swollen ankles? | Yes | No | Frequent urination? |
| Yes | No | Shortness of breath? | Yes | No | Excessive thirst? |
| Yes | No | Blurred vision? | Yes | No | Dry mouth? |
| Yes | No | Sinus problems? | Yes | No | Jaundice? |
| Yes | No | Difficulty swallowing? | Yes | No | Joint pain, stiffness? |
| Yes | No | Dizziness? | Yes | No | Recent weight loss, fever, night sweats? |
| Yes | No | Ringing in ears? | Yes | No | Bleeding problems, bruise easily? |
| Yes | No | Fainting spells? | Yes | No | Headaches? |

III. DO YOU HAVE OR HAVE YOU HAD? -----

- | | | | | | |
|-----|----|------------------------------------|-----|----|------------------------|
| Yes | No | Heart disease? | Yes | No | Arthritis, rheumatism? |
| Yes | No | Rheumatic fever? | Yes | No | Herpes? |
| Yes | No | Heart attack, heart defects? | Yes | No | AIDS, ARC or HIV? |
| Yes | No | Stroke, hardening of the arteries? | Yes | No | Eye disease? |
| Yes | No | Heart murmurs? | Yes | No | Skin disease? |
| Yes | No | Tumors, cancer? | Yes | No | High blood pressure? |
| | | | Yes | No | Anemia? |

Yes	No	Diabetes?	Yes	No	Family history of diabetes or heart problems?
Yes	No	VD (syphilis or gonorrhea?)	Yes	No	ALLERGIES: to foods latex, medications? please list _____
Yes	No	Stomach problems, ulcers?	Yes	No	TB, asthma, emphysema?
Yes	No	Kidney, bladder disease?	Yes	No	Hepatitis, other liver disease?
Yes	No	Thyroid, adrenal disease?			

IV. DO YOU HAVE OR HAVE YOU HAD? -----

Yes	No	Psychiatric care?	Yes	No	Surgeries?
Yes	No	Hospitalization?	Yes	No	Prosthetic heart valve?
Yes	No	Radiation treatments?	Yes	No	Pacemaker?
Yes	No	Blood transfusion?	Yes	No	Artificial joint?
Yes	No	Chemotherapy?	Yes	No	Contact lenses?

V. ARE YOU TAKING? -----

Yes	No	Recreational drugs?	Yes	No	Tobacco in any form?
Yes	No	Alcohol?			
Yes	No	Drugs, medicines (including aspirin or vitamins)? Please list _____			
Yes	No	Have you ever taken prescription medication for weight reduction (DIET PILLS)? If "yes," did you take any of the below listed drugs? (Please indicate with an X on line)			
		___ Fen-Phen (fenfluramine-phentermine) ___ Pondimin (fenfluramine) ___ Redux (dexfenfluramine)			
Yes	No	If you have taken any of the above drugs, have you had a medical exam to insure that your heart valves were not affected?			

VI. WOMEN ONLY-----

Yes	No	Are you or could you be pregnant or nursing?
Yes	No	Taking birth control pills?

VII. ALL PATIENTS -----

Yes	No	Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain _____
-----	----	--

VIII. DENTAL HISTORY -----

Previous Dentist _____ Date of last dental examination _____
Date of last full-mouth x-rays (18 films) _____

Yes	No	Have you had problems with prior dental treatment?
Yes	No	Are you in pain now?
Yes	No	Do your gums feel tender or swollen?
Yes	No	Do you lose fillings or break fillings?
Yes	No	Do you gag easily?
Yes	No	Have you ever had orthodontic treatment?
Yes	No	Do you like your smile? If not, what would you like to change about it? _____
Yes	No	Do you snore?
Yes	No	Do you wake up "gasping for breath?"
Yes	No	Have you ever been diagnosed or do you suspect you have sleep apnea?

To the best of my knowledge, I have answered every question completely and accurately. I will inform Dr. Huey or my hygienist of any change in my health and/or medication.

Patient's signature _____ Date: _____

RECALL REVIEW (This Section For Office Use Only) -----

1. Patient's signature _____ Date: _____
Please note any changes

2. Patient's signature _____ Date: _____
Please note any changes

3. Patient's signature _____ Date: _____
Please note any changes

4. Patient's signature _____ Date: _____
Please note any changes

5. Patient's signature _____ Date: _____
Please note any changes

6. Patient's signature _____ Date: _____
Please note any changes

7. Patient's signature _____ Date: _____
Please note any changes

8. Patient's signature _____ Date: _____
Please note any changes

9. Patient's signature _____ Date: _____
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10. Patient's signature _____ Date: _____
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AUTHORIZATION AND RELEASE TO DIAGNOSE & TREAT

1. I certify that the answers to the dental and health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or in medications can affect dental health and treatment, I understand the importance of and agree to notify _____ or staff of any changes at any subsequent appointment.
2. I hereby authorize _____ or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, and to employ such assistance as required in order to provide proper care.
3. Upon such diagnosis, I authorize _____ to perform those procedures agreed upon and deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, and to employ such assistance as required in order to provide proper care.
4. I agree to the administration of any local anesthetic, sedative, analgesic, therapeutic, and/or other pharmaceutical agent(s) including those related to restorative, palliative, therapeutic, or surgical treatments that are deemed necessary or advisable.
5. I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to: bruising, hematoma, cardiac stimulation, temporary or, rarely, permanent numbness, and muscle soreness. I do voluntarily assume any and all possible risks associated with general preventative, operative, surgical, cosmetic, or TMJ treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures, if necessary, will be explained to me and I will be given the opportunity to ask questions.
6. I authorize _____ to release any information, including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or health practitioners.
7. I understand that I am solely responsible for all treatment decisions for myself or any minor child or ward, regardless of insurance coverage. I understand that diagnosis and treatment recommendations will not be based upon what insurance dictates, but that all treatment recommendations will be, in the doctor's professional opinion, the best, most conservative, and most effective long-term options available.

Patient (or responsible party) Signature _____ Date _____

OUR FINANCIAL POLICY

1. Fees for services are due and payable at the time treatment is rendered. We accept cash, personal checks, Visa, MasterCard, or debit cards.
2. **There will be a \$100 administrative fee for missed appointments and last minute (less than 48 hours) cancellations/reschedules or changes in treatment planned.** *Appointment times are reserved specifically for you and must be treated as a serious obligation. Any last minute change in appointment scheduling affects many people. Missed appointments/ cancellations disrupt the timely delivery of necessary treatment for you and interfere with the scheduling of treatment for our other patients. In addition, each member of our dental team takes great care in planning for your visit devoting a great deal of time and attention in preparing the operatory, instruments and materials specifically for you and the planned treatment. Intensive study of your radiographs, models, occlusion and that day's specifically planned treatment are required prior to each new session with you. Please assist us in providing optimal and timely treatment to all patients by confirming and keeping your appointment.*
3. Failure to keep your account current will prevent our being able to continue to provide additional dental services to you except in an emergency dental situation. We value our doctor-patient relationship with each patient and desire to provide the best care possible. However, in order to continue to provide this care we must receive payment for services rendered.
4. In the event of default on your account, you agree to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.
5. There is a \$45 fee for any returned check.
6. For our patients with dental insurance: We are happy to assist you in filing the necessary forms to help you receive the full benefits of your coverage. *The insurance relationship constitutes an agreement between the carrier and the patient.* As such, we can make no guarantee of estimated coverage or payment. However, please know that we will do everything possible to see that you receive the full benefits of your policy.

Person Responsible For This Account: _____

Relationship to Patient: _____

___ I authorize and hereby request my insurance company to pay directly to _____ insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. ***I understand that it is my responsibility to know my insurance benefits.***

___ I authorize _____ to release all information necessary to secure payment of insurance benefits. I understand that I am financially responsible for payment of all services rendered on my behalf or on behalf of my dependants whether or not paid by insurance. Fees are due when services are rendered.

___ I understand that any insurance estimate given to me by this office is not a guarantee of actual insurance payment; insurance companies *never* guarantee coverage. I also understand that I am ultimately responsible for all charges incurred for dentistry performed upon myself or my dependents in this dental office *regardless* of estimated insurance reimbursement. Possession of insurance coverage does not negate this responsibility

___ Any insurance claim not paid in full after 30 days (from date of service) will become *my responsibility to pay immediately despite status of pending insurance claim.* Any insurance payments made after my payment will be applied as follows: 1) used to pay off any outstanding debt on my/family account; 2) credited to my account for future treatment or reimbursed directly to me.

I have read, understand, and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment or accepting appointment.

Patient (or responsible party) Signature: _____ Date: _____