WELCOME TO OUR OFFICE

Our mission is to provide you quality dental care and education that enhances your health and appearance for a lifetime. We aim to exceed your expectations with our care, service, and results in a comfortable environment using current technology.

Dental Services: We are a general dentistry office. We provide care for most procedures in our office without the need for an outside referral. In addition we have contracted providers, Dr. Roy Howard for root canal treatment and Dr. Brent Call to provide sedation dentistry for your comfort and convenience in our office.

Office Hours: Our dental treatment hours are Tuesday, Wednesday, Thursday 7am to 5pm and other times by appointment. The office is closed for major holidays as well as times when our doctors and team are attending continuing education seminars to keep abreast of the latest technology so that we may better serve you.

Emergencies: One of our doctors can be reached 24 hours a day for emergencies, simply call our office phone number and follow the directions. In return we ask for your agreement in providing us a full 48 business hours' notice if you need to reschedule an appointment. We respect your time, thank you for respecting ours. A charge may be made for broken/canceled appointments with less notice.
Cancellation Policy: Appointments rescheduled less than 48 hours in advance are subject to a $50/hour Broken Appointment Fee. _____(Please Initial)

Financial and Insurance:

- A deposit or insurance co-pay is required to schedule procedures with the doctor.
- We will bill your insurance carrier for services performed on your behalf and accept payment from your carrier for those services. You are responsible for the estimated patient portion when scheduling and any residuals due, if any, after insurance pays a claim.
- As a courtesy to you, if your carrier denies a claim, we will appeal the decision **one time**. If your carrier denies our appeal, you will be responsible for the unpaid balance. Unpaid balances that are left unpaid in an excess of 30 days are subject to a service fee. Any balance left unpaid in the excess of 45 days will be forwarded to a collection agency and accrue 15% of the remaining balance. Any additional fees assessed to our office by outside companies (collection agency, attorney, etc.) will be added to your balance.
- All returned checks are subject to a $35 insufficient funds handling fee.

Method for Resolving Discomfort: All parties desire a method for resolving misunderstandings, disputes, discomfort, if any should occur-privately, quickly, economically and in a friendly, educational manner. We therefore agree to resolve these matters using the communication, negotiation, mediation, and arbitration procedures set forth in the latest edition of the Law Forms Integrity Agreement. You may receive a copy of this standard form and information about it from our office. Unless we hear from you to the contrary, we shall assume that you are familiar with the Law Forms Integrity Agreement or have taken the time to review and understand it.

I HAVE READ AND UNDERSTAND THE ABOVE "WELCOME TO OUR OFFICE".

Signed:_____ Date: _____

Smile ARIZONA
Dr. Beth Vander Schaaf, D.D.S.

7327 E. Thomas Rd. Scottsdale, AZ 85251
Smilearizonadentistry.com | 480-994-5225

Today's Date: _____

Whom may we thank for referring you to our office? _____

Patient Name: _____
Last First MI

What You Prefer To Be Called: _____ [] M [] F

Birthdate: _____ / _____ / _____ Age: _____ SS#: _____

Mailing Address: _____

_____

Home Phone#: _____ Work Phone #: _____

Cell Phone #: _____

E-mail Address: _____

Employer: _____

Employer's Address: _____

_____

Occupation: _____

Status: [] Single [] Married [] Divorced [] Separated [] Widowed

Spouse's Name: _____

Do you have children? [] Yes [] No How Many? _____

In Event of an Emergency:

Who should we contact? _____

Relation: _____

Home Phone #: _____

Work or Cell #: _____

M.D. Name: _____

M.D. Phone #: _____

List Medical Specialists you see, (please include phone numbers): _____

_____

_____

_____

_____

_____

Nearest Friend or Relative not living with you:

Name: _____

Phone#: _____

Person ultimately responsible for account:

Name: _____

Relation: _____

Address: _____

_____

SS #: _____

(Please provide a copy of driver's license)

Driver's License #: _____

State: _____ Expiration: _____

Cell/Home Phone: _____

Work Phone: _____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any and all balances not paid by my insurance company within 45 days.

_____ **Initials**

Primary Dental Insurance (if any)

Co. Name: _____

Address: _____

_____

Phone #: _____ Group #: _____

Insured's Name: _____ Relation: _____

Date of birth: _____/_____/_____ SS#: _____

Insured's Employer: _____

Secondary Dental Insurance (if any)

Co. Name: _____

Address: _____

_____

Phone #: _____ Group #: _____

Insured's Name: _____ Relation: _____

Date of birth: _____/_____/_____ SS#: _____

Insured's Employer: _____

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Do you have or have you ever had any of the following diseases, medical conditions or procedures?

Y N **AIDS/ARC Aids Related Complex**
Positive HIV Blood Test
When? _____
Y N **Allergy to Anesthetics**
What? _____
Y N **Allergy to Latex Rubber Reaction?** _____
Y N **Anemia**
Y N **Any Bleeding/Clotting or Other Blood Disorders** _____
Y N **Any Allergies (Note Below)**
Y N **Anorexia/Bulimia/Any Eating Disorder**
What? _____
Y N **Arthritis/Rheumatism**
Y N **Asthma**
Y N **Back Problems**
What?_____
Y N **Blood Transfusion**
When?_____
Y N **Cancer/Tumors**
Diagnosed_____
Y N **Radiation or Chemotherapy?**
When?_____
Y N **Chemical/Alcohol Dependency**
What?_____
Consumed/week_____
Y N **Circulatory Problems**
Y N **Cosmetic surgery:**_____
Y N **Wear Contact Lenses**
Y N **Emphysema**
Y N **Depression treatment:**_____
Y N **Diabetes reading:**_____
Y N **Difficulty Breathing/Respiratory Problems**
Y N **Epilepsy/Seizures**
Y N **Fainting**
Y N **Frequent Fever**
Y N **Frequent Neck Pain**
Y N **Glaucoma**
Y N **Hay Fever**
Y N **Headaches;** Frequency:_____
Severity:_____
Y N **Hearing loss/Aids**
Y N **Heart Problems of any type**
Y N **Heart attack/stroke;** when_____
Y N **Heart Surgery;** when_____
Y N **Heart Murmur;** diagnosed:_____
Y N **Rheumatic Fever, Scarlet Fever or Congenital Heart defect**
Y N **Angina/Chest Pains**
Y N **Artificial Heart Valve**
Y N **Mitral Valve Prolapse/Floppy Valve**
Y N **Pacemaker;** placed:_____
Y N **High blood pressure**
Y N **Low Blood Pressure**
Y N **Hepatitis type**_____
Y N **Hypoglycemia**
Y N **Implants of any time**
What?_____
Artificial Joints etc. :_____
Y N **Jaw Problems - TMD/TMJ**
Left Right Both (circle one)
Y N **Kidney Disease**
Y N **Liver Disease**
Y N **Nervous Problems**
Y N **Night Sweats**
Y N **Recreational Drug Use;**
what:_____
Y N **Shingles;** when:_____
Y N **Sinus problems**
Y N **Swollen Lymph Nodes**
Location: _____
Y N **Thyroid Condition;** what_____
Y N **Tuberculosis/TB;** when_____
Y N **Ulcer/Stomach Problems**
Y N **Unexplained Weight Loss**

Reason for today's visit: [] Exam [] Emergency [] Consultation
Are you in pain? [] Yes [] No How long? _____

Please indicate any of the following problems:
[] Discomfort, Clicking, Popping or Locking Jaw [] Lost/Broken Filling(s) [] Stained Teeth
[] Red, Swollen or Bleeding Gums [] Teeth Grinding/Clenching [] Bad Breath
[] Sensitive Tooth, Teeth, Gums or Jaw [] Ringing in Ear [] Other: _____
[] Blisters/Sores in or Around the Mouth [] Broken/Chipped Teeth _____
[] Food Catching Between Teeth [] Swelling or Sore(s) in Mouth _____

Do you require pre-medication? [] Yes [] No [] Don't Know
Previous Dentist:_____ Phone #:_____
Last Dental Exam:_____ Last Dental X-Rays:_____
How often do you brush? _____ How often do you floss?_____
What type of toothbrush do you use? [] Manual (what kind) _____ [] Electric (what kind) _____

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)
Are you satisfied with your smile? [] Yes [] No
Do you have dental anxiety? (None) 1 2 3 4 5 6 7 8 9 10 (High)
Have you ever had your teeth straightened? [] Yes [] No
Have you had any unfavorable reaction associated with dental treatment? [] Yes [] No
If yes, please explain:_____
Have you been satisfied with your previous dental care? [] Yes [] No
If no, please explain:_____
Would you like to keep your natural teeth? [] Yes [] No
Have you ever been treated for Periodontal Disease (Gum Disease)? [] Yes [] No
Has anyone in your family ever been treated for Periodontal Disease? [] Yes [] No
Do you have any removal partials or dentures? [] Yes [] No

Please list all medications you take, prescription and over the counter, include vitamins, herbals & supplements:
_____
_____

Are you taking any of the following medications?
[] Nerve Pills [] Pain Killers (including aspirin) [] Muscle Relaxers [] Stimulants
[] Blood Thinners [] Tranquilizers [] Insulin [] Other(s): _____

Please list any other medical condition(s) you have or ever had:
_____

Are you allergic to any of the following?
[] Latex [] Penicillin/Amoxicillin [] Tetracycline [] Aspirin [] Dental Anesthetics
[] Others: _____
Do you use tobacco? [] No [] Yes - How Used? _____ How Much? _____ How long? _____
Please rate your general health from 1-10: _____
For Women: Are you taking birth control pills? [] No [] Yes

* Antibiotics can make the pill ineffective for one month past month(s) of ingestion *
Are you pregnant? [] No [] Yes/How Long? _____ Are you nursing? [] No [] Yes

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient. Our policy requires that patient portion is paid in full for all services rendered by the time of visit. If account is not paid in full within 45 days of the date of service, regardless of insurance status, you will be responsible for interest charges, collection agency fees and any other expenses or legal fees incurred in collecting your account.

- I give authorization to the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims or to aid in my treatment at any dental specialist to which I or the patient is referred.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes to the information that I have provided.
- I give my permission to have my health discussed with my medical doctors of record and those that I have noted on this form.
- I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. Details available at the front desk.

Signature: _____ Date: _____

[] Adult Patient [] Parent or Guardian (print name) _____

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As a service to our patients, Smile Arizona Dentistry will file insurance claims for services performed on your behalf, and accept payment for those services from your insurance carrier.

We strive to be as accurate as possible when estimating your benefits with your carrier for treatment; however until the claim is settled, any estimates given are not a guarantee of benefits. In addition, periodically your insurance carrier will even deny claims for services performed. In the event this occurs, we will appeal the decision on your behalf and submit the necessary appeal documents.

Occasionally, an appeal will be denied, and you will be responsible for this balance. In the event your carrier under pays or denies a claim resulting in a balance on your account, we would like to keep a copy of your credit card on file to process any balance unpaid by insurance.

**Most charges are for small, balance differences between estimated and actual payments and are typically less than $100.00. Please keep in mind that your carrier will send all updates to you as claims are paid and closed.*

Name on Card: _____

Acct #: _____

Exp:_____ CVD: _____

Please sign below to authorize payment processing for any unpaid insurance balance:

Authorized Signature:_____Date: _____

Alternate Card Information

Name on Card: _____

Acct#: _____

Exp:_____ CVD: _____

Authorized Signature:_____ Date:_____

We respectfully request a card on file. If you request a call prior to charging, please note it here:

___ (Initial) Call me before initiating any charge

___ (Initial) Call me for any charge over $_____ (fill in amount)

Insurance Agreement

To our patients requesting that we file your insurance: please read and sign this form (responsible party) for us to accept payment directly from your insurance company.

1. Please remember that professional dental services are rendered and charged to you, the patient, not to an insurance company. You are responsible for the payment of all treatment fees on your account. If your insurance company fails to pay within **45 days**, you are agreeing to pay your account in full. We will always continue to re-file paper work, etc. on your behalf and exhaust your options.

2. We will file but cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a claim. You are responsible for payment of your account.

3. Insurance deductibles and "co-payments" are due when scheduling for such procedure(s).

4. Our office is willing but cannot make a totally accurate estimate of your insurance benefits to be paid since we do not have access to your insurance company records and insurance companies generally will only discuss **exact** fees with people they insure. Many insurance companies pick and choose randomly what they will and will not cover. It is your sole responsibility to know the terms, agreements and amounts of coverage of your dental/medical insurance benefit contracts.

5. After each insurance claim is paid to our office by your carrier, we request to settle your balance by your credit card on file. We request that you pay any difference indicated to keep your account balance in full. Your insurance company keeps us both informed in writing as claims are paid. We are happy to help with your questions as is your insurance carrier.

6. Thank you! We will make every effort to help you receive full value for any dental "insurance" you participate in. **We appreciate all your efforts in keeping your account current so we can focus all our efforts on patient care.**

   Our conscience and desire for your optimal health drives our treatment plans, not limitations or restrictions imposed by third parties.

_____ _____
Signature of Responsible Party Date

_____
Printed Name of Responsible Party

_____
Printed Name of Patient (If different from Responsible Party)

Dr. Beth Vander Schaaf

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, as required by law, 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:

_____

Medical Insurance Information (Not Dental Insurance)

Insurance Company: _____

ID#: _____

Group#: _____

Subscriber: _____

Subscriber DOB: _____

Relationship to Patient: _____

Insurance Phone Number: _____

Insurance Company Address:

_____

_____

Secondary Medical Insurance Information (if applicable)

Insurance Company: _____

ID#: _____

Group#: _____

Subscriber: _____

Subscriber DOB: _____

Relationship to Patient: _____

Insurance Phone Number: _____

Insurance Company Address:

_____

_____

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We will send you a text and email reminder for your upcoming visit:

- ☑ **IMMEDIATELY WHEN YOU SCHEDULE A VISIT**
- ☑ **ONE WEEK PRIOR TO YOUR APPOINTMENT**
- ☑ **THREE DAYS PRIOR TO YOUR APPOINTMENT**

<u>IMPORTANT!!!</u> You will continue to receive reminders from our office until you confirm the appointment via text or email. Once you confirm your appointment, you will no longer receive reminders.

Please list your preferred method of contact for general correspondence:

Email:_____

Cell:_____

Home Phone: _____

We ask that you notify us a minimum of 48 business hours in advance to cancel or change an upcoming appointment.

Appointments not cancelled or rescheduled with a 48-hour notice are subject to a late cancellation fee.