Laws Family Dentistry
8811 N. 51st Ave.
Suite 108
Glendale AZ 85302
(623)934-0938
info@lawsfamilydental.com
www.lawsfamilydental.com

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart #. ______
FOR OFFICE USE ONLY

Patient Name: ______ Last ______ First ______ MI ______ Preferred Name

Title: ______ Mr/Ms/Mrs/etc Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ______ SS #. ______ Prev. Visit: ______

Email Address: ______ Best time to call: ______

Phone: ______ Home ______ Work ______ Ext ______ Mobile ______ Fax ______ Other

Address: ______ ______
______ City ______ State ______ Zip Code

If Student, Name of School/College Attending? (Include City,State and Full or Part-Time Status)

______

How would you like us to communicate with you?

- ☐ Home Phone
- ☐ Cell Phone
- ☐ Work Phone
- ☐ Email
- ☐ Text Message

Whom may we thank for referring you to our practice?

______

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: ____ Last ____ First ____ MI ____ Preferred Name

Title: ____ Mr/Ms/Mrs/etc Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ____ Email Address: ____

Phone: ____ Home ____ Work ____ Ext ____ Mobile Best time to call: ____

Address: ____ ____
____ City ____ State ____ Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ____ Phone: ____

Address: ____ ____
____ City ____ State ____ Zip Code

Emergency Contact

Name: ______________________________ Relationship: _________________ Phone: ___________________

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: ______ Last ______ First ______ MI

Insured's Birth Date: ______ ID #. ______ Group #. ______

Insured's Address: ______ ______
______ City ______ State ______ Zip Code

Insured's Employer Name: ______

Employer Address: ______ ______
______ City ______ State ______ Zip Code

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: ______

Insurance Address: ______ ______
______ City ______ State ______ Zip Code

Secondary Insurance Information

Secondary Dental Insurance:

Name of Insured: ____________ Last ____________ First ____ MI

Insured's Birth Date: ____________ ID #. ____________ Group #. ____________

Insured's Address: ____________ ____________

____________ City ____ State ____________ Zip Code

Insured's Employer Name: ____________

Employer Address: ____________ ____________

____________ City ____ State ____________ Zip Code

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: ____________

Insurance Address: ____________ ____________

____________ City ____ State ____________ Zip Code

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Patient Name: ______ ______ ______ ______
Last First MI Preferred Name

Patient Medical History

Name and Phone Number of your Physician:

Are you currently under medical care?

Yes No

Are you currently taking any medication(s) including non-prescription medicine?

Yes No

If Yes, Please List Medications you are Currently taking:

Do you require Antibiotics prior to dental procedures?

Yes No

Do you use controlled substances?

Yes No

Have you ever taken Fosamax, Boniva, Actonel or any Cancer Medications containing Bisphosphates?

Yes No

For Women Only: Are you pregnant or think you may be pregnant? (Due Date)

Yes No

For Women Only: Are you taking oral contraceptives?

Yes No

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Patient Name: ______ Last ______ First ______ MI ______ Preferred Name

Do you have or have you ever had any of the following:

- [ ] Abnormal Heart Cond.
- [ ] ADHD
- [ ] AIDS/HIV
- [ ] Allergies
- [ ] Anemia
- [ ] Angina
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Asprin Allergy
- [ ] Asthma
- [ ] Autism
- [ ] Back Problems
- [ ] Blood Disease
- [ ] Blood Thinner
- [ ] Cancer
- [ ] Chemical Dependency
- [ ] Codeine Allergy
- [ ] Demerol Allergy
- [ ] DENTAL PHOBIA
- [ ] Diabetes
- [ ] Dizziness
- [ ] Emphysema
- [ ] Epilepsy
- [ ] Epinephrine Allergy
- [ ] Erythromycin Allerg
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] GAG REFLEX!!
- [ ] Glaucoma
- [ ] Headaches
- [ ] Heart Attack
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Heart Problem
- [ ] Hepatitis
- [ ] Herpes
- [ ] High Blood Pressure
- [ ] Ibuprofin Allergy
- [ ] Implants
- [ ] Kidney Disease
- [ ] LATEX Allergy
- [ ] Liver Disease
- [ ] Local Anesth.Allergy
- [ ] Low Blood Pressure
- [ ] Mental Disorders
- [ ] Mitro-Valve Prolapse
- [ ] Nervous Disorders
- [ ] Pacemaker
- [ ] Penicillin Allergy
- [ ] Percodan Allergy
- [ ] Pre-Medicate
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Seizures
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Sulfa Allergy
- [ ] Thyroid Problem
- [ ] Tobacco Habit
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Venereal Disease

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HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a friendly version. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patients condition or information that is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, personal health information and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, Text Message or by any means convenient for the practice and/or as requested by you. We may send you other communication informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to our office but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents, which may include personal health information by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient as permitted by applicable law.

9. You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

I hereby consent and acknowledge my agreement to the terms set forth in the HIPPA Information Form and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signature: ______________________ Date: ____________

Authorization and Release

I certify that I have read and understand the prior information to the best of my knowledge. The prior questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such Dental care to third party payors and/or health practitioners after written consent. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that if my account is not paid within 90 days of the date of service and no financial arrangements have been made, I will be responsible for any and all legal fees, collection agency fees and any other expenses incurred in collecting my balance.

24 Hour Appointment Cancellation/Re-Schedule Guidelines

At our office, we value your time. We make every effort to keep on schedule. We respectfully ask that you value our time by being prompt and keeping appointments as scheduled. We ask that you give us a minimum 24-hour business day notice to change or cancel your appointment. This allows us to be able to offer the time to another patient. Should you have to cancel with insufficient notice, your account will be charged $50 per hour of time scheduled. Exceptions to this rule can only be determined on an individual basis according to your circumstances. As always, we appreciate your understanding.

☐ By checking this box. I acknowledge that I have read this statement and agree to the contents.

Signature of patient, parent, or guardian (responsible party):

Signature: ______________________ Date: __________

Relationship to Patient: __________

Response Date: __________