8154 E. Florentine Rd., Ste. B
Prescott Valley, AZ 86314
P: (928) 772-8175 F: (928) 772-8351
www.pvdentistry.com

PATIENT INFORMATION AND INSURANCE FORM

Patient Name: _____ Preferred Name: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Date of Birth: _____/_____/_____ Social Security: _____-_____-_____ Gender: Male ____ Female ____

Address: _____

City: _____ Zip Code: _____ Drivers License # _____

Referred By: _____ Marital Status: Single ___ Married ___ Divorced ___ Widowed___

Emergency Contact: _____ Phone: _____

Employer: _____ Phone: _____

May we contact you at work? _____ Responsible Party: _____

DENTAL INSURANCE INFORMATION

Primary: _____ Group # _____ Policy/ID #:_____

Subscriber Name: _____ Relation to patient: _____

Subscriber Address: _____

Subscriber Phone: _____ Subscriber DOB: _____/_____/_____ Sex: ___ Male ___ Female

Subscriber Employer: _____ Subscriber Social Security: _____-_____-_____

MEDICAL INSURANCE INFORMATION

Primary: _____ Group # _____ Policy/ID #:_____

Subscriber Name: _____ Relation to patient: _____

Subscriber Address: _____

Subscriber Phone: _____ Subscriber DOB: _____/_____/_____ Sex: ___ Male ___ Female

Subscriber Employer: _____ Subscriber Social Security: _____-_____-_____

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I certify that the information contained in the “Patient Information and Insurance Form” are true, complete and correct to the best of my knowledge.

Signature of Patient or Responsible Party: _____

Printed Name: _____ Date: _____/_____/_____

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SYSTEMIC HEALTH: (Have you ever had or do you currently have any of the following conditions?)

SKIN:	YES
Itching, Rash, Ulcers	
Pigmentations	
Lack or loss of body hair	

EXTREMITIES:	YES
Swollen, painful joints	
Muscle weakness, pain	
Bone deformity, fracture	
Prosthetic joints	

EYES:	YES
Blurring of vision	
Double Vision	
Drooping of eyelid	
Glaucoma	

EAR, NOSE, THROAT:	YES
Earache	
Hearing loss	
Frequent nosebleeds	
Sinusitis	
Frequent sore throat, hoarseness	
Dry mouth	

RESPIRATORY:	YES
Cough blood in sputum	
COPD, emphysema, bronchitis	
Asthma, wheezing	
Tuberculosis, exposure to	

CARDIAC:	YES
Shortness of breath	
Swelling of ankles	
Mitral valve prolapse, murmur	
Pain, pressure in chest, angina	
High, low blood pressure	
Rheumatic, Scarlet fever	
Heart attack, failure	
Heart surgery, stents, bypass	
Prosthetic valve, pacemaker	
Other heart disease	

GASTROINTESTINAL:	YES
Difficulty swallowing	
Abdominal pain, ulcers	
Hepatitis A, B, C, jaundice	
Liver disease	

GENITOURINARY:	YES
Difficulty, pain on urination	
Blood in urine	
Kidney disease, infections	
Sexually transmitted disease	

ENDOCRINE:	YES
Thyroid, hyper-, hypo-	
Sudden weight change	
Diabetes, I, II	
Excessive thirst	

HEMATOPOIETIC:	YES
Easy bruising, excessive bleeding	
Anemia	
Persistent lymphadenopathy	
HIV infection, AIDS	
Leukemia	
Immune system disorder	
Spleen disorder	
Other blood or bleeding disorder	

NEUROLOGIC:	YES
Migraines, headaches	
Stroke	
Dizziness, fainting, vertigo	
Epilepsy	
Neuralgia, parasthesia, numbness	
Paralysis	

PSYCHIATRIC:	YES
Nervousness, irritability	
Depression	
Anxiety, excessive worry	
Nervous breakdown	

GROWTH OR TUMOR:	YES
Cancer or tumor	
Chemotherapy	
Radiotherapy	

OTHER:	YES
Hypoglycemic	
Crohn's disease	
Fibromyalgia	
Alcohol or chemical dependency	
Organ transplant	

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Name: _____ Date: _____

If the person completing this form is someone other than the patient, what is his/her relationship to the patient?

_____

DENTAL HISTORY:

When was your last visit to the dentist? _____

What was the reason for your last visit? _____

Have you had any difficulties with past treatment? _____

Do you take antibiotics before every dental appointment (premedicate)? _____ Why? _____

FAMILY HISTORY:

Have any members of your family ever been diagnosed or treated for the following conditions?

Diabetes? _____ High Blood Pressure? _____ Heart Problems? _____ Depression or Bipolar Disorder? _____

Gum Disease? _____ Seizures? _____

Do any of your family members wear dentures? _____ Relationship? _____

SOCIAL HISTORY:

Do you or have you ever smoked? _____ How many cigarettes per day? _____ How many years? _____

How often do you drink alcohol? _____ Other (e.g., chew)? _____

MEDICAL HISTORY:

Are you now or have you been under the care of a physician during the past 12 months? _____

Date of last visit with physician: _____ Reason for last visit: _____

Physician's Name: _____ Phone Number: _____

Have you been to the hospital or had an inpatient/outpatient procedure or operation in the last 5 years? _____

Procedure? _____ Date: _____

Allergies or Sensitivities: Latex or Acrylics? _____ Antibiotics (Penicillin)? _____ Fruits? _____ Metals? _____

Local anesthetic (Novocaine)? _____ Codeine or other narcotic? _____ Sulfa drugs? _____ Other? _____

Females: Oral contraceptives? _____ Could you be pregnant? _____ Are you nursing? _____

Do you take any medications at the present time? _____

MEDICATIONS: (*If you are taking more than five medications, please provide us with a current list*)

	NAME	DOSAGE
1.	_____	
2.	_____	
3.	_____	
4.	_____	
5.	_____	

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To the best of my knowledge, the questions on these forms have been accurately answered. I understand that incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the doctor of changes in medical and dental statuses that occurs between appointments.

Signature of patient, parent or guardian: _____

Date: _____

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INSURANCE AGREEMENT

To our patients who are requesting that we file their insurance: this form must be read, understood and signed by the responsible party before we can accept payment directly from an insurance company.

1. Patients who carry dental insurance should remember that professional services are rendered and charged to the patient and not to the insurance companies. You are responsible for the payment of all treatment fees on your account. If your insurance company fails to pay or fails to pay within **60** days, you will be responsible to pay your account in full.

2. Our office will file, but does not accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. You are responsible for payment of your account.

3. It is your sole responsibility to know the terms and agreements of your dental insurance benefit contract.

4. Our office can not make a totally accurate estimate of your insurance benefits to be paid since we do not have access to all of your insurance records. Many insurance companies pick and choose randomly what they will and will not cover.

5. Upon payment by your insurance company, if there is a remaining balance, it is due and to be paid in full at the time of billing.

_____ _____
Signature of Responsible Party Date

_____
Printed Name of Responsible Party

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SIGNATURE RELEASE STATEMENT

YOUR SIGNATURE IS NECESSARY FOR US TO:

1. **PROCESS ALL INSURANCE CLAIMS.**
2. **ENSURE PAYMENT FOR SERVICES PROVIDED.**
3. **RELEASE MEDICAL INFORMATION TO INSURANCE COMPANIES NEEDED FOR THE PROCESSING OF YOUR CLAIMS.**
4. **RELEASE INFORMATION TO OTHER MEDICAL AND DENTAL PROVIDERS, INCLUDING LABORATORIES, WHEN NECESSARY, FOR YOUR TREATMENT.**

I hereby authorize the release of all medical information necessary to process my claims and I authorize release of this same information, when necessary, to other providers rendering medical/dental care, as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment.

I authorize and request my insurance company to pay directly to Dr. Matthew D. Bergman/PV Dentistry LLC any health benefits resulting from care received in that facility. I understand that my insurance company may not cover all services rendered on behalf of me or my dependents and agree to assume responsibility for any services not covered. I consent to the release to my insurance company any medical record necessary to resolve claims for services rendered. I understand co-pays and any services not covered by an insurance company are DUE IN FULL AT THE TIME OF SERVICE. I assign all medical benefits, including diagnostic and surgical benefits and major medical benefits to which I am entitled, to Dr. Matthew D. Bergman/PV Dentistry LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient Signature _____ Printed Name: _____

Parent Signature (if minor) _____

Witness _____ Date: _____/_____/_____

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PATIENT MISSED APPOINTMENT POLICY

We strive to provide our patients with utmost professional and excellence of service. Our commitment to your well being is something everyone in our practice takes seriously. Because we care about you, we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive.

We expect you to keep all appointments. In most cases, we will give an appointment card with the time and date of your scheduled visit. We will also attempt to make a reminder call on the business day prior to your appointment.

With the exception of serious emergencies, it is expected that you will keep your appointments. If you need to reschedule an appointment we require **A FULL BUSINESS DAYS NOTICE.** This means communicating with us during business hours and not leaving a cancellation notice on the answering machine.

In the instance of a cancellation without the full business days notice or a **NO-SHOW** to a scheduled appointment, we reserve the right to charge you a **FEE.** In instances of repeated non-compliance with your scheduled visits, we will withdraw from seeing you for your Dental Care. This does not exempt you of your financial responsibilities.

I have read and understand this policy.

_____ _____

Patient/parent/guardian signature Date

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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 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 personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: Treatment, Payment, and Health Care Operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example would include specialty or hygiene services.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individual identifiable information. We may contact you to provide appointment reminders of information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Policy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information from us by alternate means or at alternate locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to obtain and we have the obligation to provide to you a paper copy of this notice from us at your first service delivery date.
- The right to provide and we are obligated to receive a written acknowledgement that you have received a copy of our Notice of Privacy Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of January, 2005 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Pricy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below. We will not retaliate against you for filing a complaint.

Please feel free to contact us for more information if you would like.

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OUR PRIVACY PLEDGE

Because we value you as our patient we are concerned with protecting your privacy. While the law requires us to give you the attached disclosure, please understand that we have, and always will, respect the privacy of your health information.

The staff at this office has received and reviewed the Health Information Privacy Policies and Procedures in compliance with the Health Insurance Portability and Accountability Act (HIPAA) that became effective April 15, 2003.

We appreciate your taking time to read and review and sign the following documents:

Notice of Privacy Practices
Insurance Agreement
Signature Release Statement

In signing this you agree to the existing practices of this office regarding record storage, charting practices, documentation, and daily operations of this practice. You agree to allow PV Dentistry LLC to use and disclose pertinent health information for medical purposes, billing purposes and laboratory purposes. You also agree to continue receiving the mailed hygiene recall postcards and/or our courtesy calls for your appointments that may be left on your answering machine.

I have read the above mentioned policies and agree to its terms. I am also acknowledging that I have received copies of these documents to take home with me, and have also signed and dated those documents.

_____

Signature Date

_____

Printed name