PATIENT INFORMATION

Today's Date: _____

Name: _____

__ Male __ Female

Date of Birth: _____ Social Security #: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____ E-mail _____

Employer: _____ Business Phone: _____

Where do you prefer to be contacted? __ Home __ Mobile __ Business __ E-mail

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

DENTAL INSURANCE INFORMATION

Name of Insured Person: _____ Relationship to Patient: _____

Employer of Insured Person: _____

Social Security # or ID #: _____ Date of Birth: _____ Group #: _____

Dental Insurance Company Name: _____ Insurance Phone #: _____

RESPONSIBLE PARTY

If the person responsible for payment is someone other than the patient, please complete the section below so that we have the appropriate billing information for your account.

Name of Person Responsible for Payment: _____ Relationship to Patient: _____

Home Address: _____
City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____ E-mail _____

HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Physician Name (optional): _____ Preferred Pharmacy: _____

Do you take any Medications? ___ **Yes, *please list* all medications and the reason why you are taking them below** ___ **No**

_____

_____

Do you smoke cigarettes or use smokeless tobacco? ___ **Yes** ___ **No**

Have you ever taken oral or intravenous **bisphosphonate** drugs for osteoporosis, metastasis cancer, or other conditions? Examples include: aldendronate (*Fosamax*), risedronate (*Actonel*), pamidronate (*Aredia*) and zoledronate (*Zomeca*). ___ **Yes** ___**No**

Are you allergic to any of the following (circle yes or no)?

1. Penicillin **Yes No** 3. *Latex* **Yes No** 5. *Local Anesthetics* **Yes No**

2. Sulfa Drugs **Yes No** 4. *Other* **Yes** _____ **No**

Do you have, or have ever had, any of the following?

Yes	No		Yes	No	
___	___	Alcohol or drug addiction	___	___	High blood pressure
___	___	Anemia	___	___	HIV or AIDS
___	___	**Artificial joint replacement** (hip, knee, etc) Date _____	___	___	Kidney problems
___	___	**Artificial heart valve, stents, shunts** Date _____	___	___	Liver problems
___	___	Asthma	___	___	Psychiatric care
___	___	Cancer	___	___	Radiation treatment
___	___	Congenital heart defect	___	___	Respiratory problems
___	___	Corticosteroid treatment	___	___	Rheumatic fever
___	___	Dental phobia or anxiety	___	___	Sinus problems
___	___	Diabetes	___	___	Stomach or intestinal problems
___	___	Epilepsy or seizures	___	___	**Stroke** Date _____
___	___	Excessive bleeding	___	___	Thyroid problems
___	___	Fainting spells or dizziness	___	___	Tuberculosis
___	___	**Heart attack** Date _____	___	___	Tumors or growths
___	___	Heart murmur	___	___	Other health problems
___	___	Heart pacemaker	___	___	**If female**, are you pregnant?
___	___	Heart surgery	___	___	**If female**, do you take birth control pills?
___	___	Hepatitis			
___	___	Herpes or cold sores			

Please provide additional information for all of the "yes" responses:

_____

_____

Signature: _____ **Date**: _____

***Parent or Guardian signature required if patient is under the age of 18.**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient authorizes communication with the following. Please list below with whom we may speak with regarding your medical/dental care and their relationship to you.

Name	Relationship	Phone number
Name	Relationship	Phone number

For more information about HIPPA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independent Avenue, S.W.
Washington, D.C. 20201
(202)619-0257 or 1-877-696-6775

Patient Name: _____

Signature: _____ Date: _____

Parent or Guardian signature required if patient is under the age of 18.

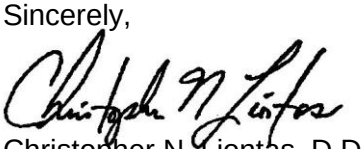
BROKEN APPOINTMENT POLICY

Dear Patient,

The Desert Hawk Dental Team including myself takes great pride in offering our patients the highest quality dental care. We pay special attention when scheduling to make sure our patients receive their recommended treatment in a reasonable amount of time, while also making our best effort to accommodate all individual needs. It is of utmost importance for our patients to be on time for their scheduled appointments.

We would also like to make you aware of our office policy regarding no-show appointments and last minute cancellations. When an appointment is cancelled without a 24-hour notice, or if a patient fails to arrive for a scheduled appointment, the patient will be charged $30.00.

Sincerely,



Christopher N. Liontas, D.D.S.

Patient Name: _____

Signature: _____ Date: _____

Parent or Guardian signature required if patient is under the age of 18.

INSURANCE BILLING/PAYMENT POLICY

Dear Patient,

Thank you for choosing our practice for your dental needs. You have indicated to us that you have the good fortune to be covered by some form of dental insurance. We would like to clarify our policies and procedures related to the handling of your insurance claims.

- Insurance is designed to help pay part of the cost of dental treatment. Your employer has made this contract available to you, and we will do our best to help you maximize your benefits. Dental insurance is not designed to pay the entire cost of treatment, but rather to assist you in paying for that treatment.

- Your insurance contract is between you, your employer, and the insurance company. The type of benefits in your contract depends upon what your employer has negotiated with the insurance company and the amount of money paid in premiums. There is no direct relationship between our office and your employer, labor union, or insurance carrier.

- You are contracting our services and are entitled to quality dental care in a pleasant environment. We are entitled to prompt compensation for services provided to you.

As a courtesy to our patients, we will complete an approved insurance claim form and forward it to your primary insurance carrier. Your portion of the fees will be approximated at the time of your appointment, and this amount is due at the completion of that visit. Disputes as to coverage, treatment plans, etc. are strictly between you and your insurance company. It would be to your advantage for you to check your policy prior to treatment for covered benefits. You, as the patient, are ultimately responsible for all charges incurred in our office.

When significant amounts of dental treatment are involved, we will, upon your request, submit the information to your insurance company for pre-authorization. Submission of the pre-authorization request does not in any way obligate you to any part of the proposed treatment plan.

Should you have any questions, please feel free to ask for clarification.

Sincerely,

Christopher N. Liontas, D.D.S.

Patient Name: _____

Signature: _____ Date: _____

Parent or Guardian signature required if patient is under the age of 18.