Welcome to Douglas Dental, LLC

Section A Patient Information

Today's Date: _____

Patient Name:_____ Male_____ Female_____

Address:_____ City:_____ State:_____ Zip Code:_____

Phone #'s: Home:_____ Cell: _____Work:_____ Marital Status:_____

Date of Birth: _____/_____/_____ Social Security Number:_____/_____/_____

If the patient is a minor please complete the following information:

Father's Name:_____ Date of Birth:_____/_____/_____

Employer:_____ Occupation:_____ Work Phone: _____

Mother's Name:_____ Date of Birth:_____/_____/_____

Employer:_____ Occupation:_____ Work Phone: _____

Section B Medical History

Date of last Dental visit:_____ Reason for today's visit:_____

Have you ever had any of the following? Please check those that apply:

□HIV/AIDS	□Blood Disease	□Hay Fever	□Mental Disorder	□Sinus Problems
□Allergies_____	□Cancer	□Head Injuries	□Nervous Disorder	□Stoke
_____	□Diabetes	□Heart Disease	□Pacemaker	□ Stomach Problems
□Allergy: Codeine	□Dizziness	□Heart Murmur	□Radiation Treatment	□Tuberculosis
□Allergy: Penicillin	□Epilepsy	□Hepatitis	□Respiratory Problems	□Tumors
□Anemia	□Excessive bleeding	□High Blood Pressure	□Rheumatism	□Venereal Disease
□Arthritis	□Fainting	□Jaundice	□Rheumatic Fever	□Ulcers
□Artificial Joints	□Glaucoma	□Kidney Disease	□Currently Pregnant	□Other:_____
□Asthma	□Growths	□Liver Disease	Due Date: _____	_____

Have you ever had any complications following dental treatment? □YES □NO

If yes, please explain: _____

Have you been admitted to a hospital or emergency room during the past two years? □YES □NO

If yes, please explain: _____

Are you under the care of a Physician? □YES □NO

If yes, please explain: _____

Do you have any health problems that need further clarification? □YES □NO

If yes, please explain: _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: _____

_____

Name of physician: _____ Phone of Physician: _____

To the best of my knowledge, all preceding answers and information provided are true and correct. If I ever have change in my health, I will inform the doctors at the next appointment without fail.

_____ _____

Signature of patient, parent or guardian Date

Douglas Dental, LLC
855 Cochise Ave
Douglas, AZ 85607
(520)364-3361

SECTION C **PATIENT EMPLOYMENT INFORMATION** **□NOT APPLICABLE**

Occupation: _____ Employer: _____

Employer's Address: _____

STREET/CITY/STATE/ZIP PHONE

SECTION D **SPOUSES INFORMATION** **□NOT APPLICABLE**

Name: _____ Male□ Female□ DOB: _____ SS#_____

Phone: _____

HOME WORK CELL

Occupation: _____ Employer: _____

Employer's Address: _____

STREET/CITY/STATE/ZIP PHONE

SECTION E **INSURANCE INFORMATION** **□NOT APPLICABLE**

PRIMARY:

Insurance Plan Name: _____ ID#_____ Group#_____

Insurance Plan Address: _____

STREET/CITY/STATE/ZIP

Name of Insured: _____ DOB: _____ Is insured a patient? □ Yes□ No

Last/First/Mi Patient's relationship to insured: □Self □Spouse □Child □Other

Insured's Address: _____

STREET/CITY/STATE/ZIP

Insured's Employer Name & Address: _____

STREET/CITY/STATE/ZIP

SECONDARY:

Insurance Plan Name: _____ ID#_____ Group#_____

Insurance Plan Address: _____

STREET/CITY/STATE/ZIP

Name of Insured: _____DOB:_____ Is Insured a Patient? □Yes □No

Last/First/Mi Patient's relationship to Insured: □Self □Spouse □Child □Other

Insured's Address: _____

STREET/CITY/STATE/ZIP

Insured's Employer Name &Address: _____

STREET/CITY/STATE/ZIP

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid in cash at time of service performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the Patient and that he or she is personally responsible for payment for all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patients account. However this dental office cannot render services on the assumption that our charges will be paid by the insurance company.

A service fee of 1 ½ % per month (18%per annum) on the unpaid balance will be charged on all accounts exceeding 60 days , unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. In consideration for the professional services rendered, to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee at the time said services are rendered, or within (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I grant permission to you or your assignee, to telephone me at my home or at my work to discuss matters related to this form. The parent or guardian is required to remain in this DENTAL OFFICE during their child's dental treatment. I have read the above conditions of treatment and payment and agree to their content.

_____

Signature of patient, parent or guardian Date Relationship to patient

_____

Signature of guarantor of payment/responsible party Date Relationship to patient

Patient Acknowledgement of Privacy Practices

I give Douglas Dental my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies and for health care operations like quality reviews.

I have been informed that I may review the practice Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing the consent.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Print Name _____ Date of Birth_____

Signature _____ Date _____

If signed by parent or legal Guardian, please state relationship to patient _____

Patient's Name _____ Date of Birth _____

Douglas Dental, LLC

Dr. Jared W. Haws, Dr. Michael A. Leavitt, & Dr. David I. Dahl
855 Cochise Ave Douglas, AZ 85607

We appreciate you choosing Douglas Dental, LLC for your dental needs. Our goal is to provide you with the best quality care possible. In doing so, we have established the following payment policy effective immediately.

Insurance Plans

We are contracted providers for many insurance companies. Please understand that not all types of services are covered under your plan benefits. You will be responsible for any amount left unpaid by your insurance. Please refer to your plan booklet for covered benefits.

For most other insurance companies we are not contracted with we will gladly submit a claim on your behalf; however, you will be responsible for your "estimated" portion due at the time of service. Since we are not participating with your plan please understand that we can only estimate what your portion due will be. You will be responsible for any amount left unpaid by your insurance.

Method of Payment Accepted

Cash, Money order, Cashier's Check, Visa, Master Card, Debit Card, and Care Credit.

All payments are due at the time services are render or at least one week before, for appointments 1 ½ hours or longer. Any special financial arrangements must be made prior to your appointment time.

Failed Appointments

We require 48 hours notice for cancellation of appointment. Insufficient notice is not give the following fees may apply- $25 for the first hour of your appoint ($25 minimum charge) and $25 for each additional hour of your scheduled appointment.

Patient/Parent or Guardian Signature _____
Date _____