VISTOSO DENTAL Partners

Today's Date: _____

Name: _____ I prefer to be addressed as: _____ ☐ Male ☐ Female
Last First MI Mr. Mrs. Ms. Dr.

Birth date: ___/___/___ Age: _____ Social Security #:_____ Employer/Occupation: _____

Mailing Address: _____
Street City State Zip

Home Phone #: (___) _____ Work Phone #: (___) _____ Ext. _____ Cell Phone # :(___) _____

Email: _____ How would you like us to confirm appointments? ☐Home ☐Cell ☐Work ☐Email

Whom may we thank for referring you? _____

Spouse OR Guadian Information

His/ Her Name: _____ Work/Cell Phone # (____) _____

Dental Insurance Information

Dental Coverage? **Yes No** **If yes, must be completely filled out.** If no, person responsible for this account: _____

Primary Dental Insurance Co. Name: _____ Phone #: (____) _____
Group #:_____

Insured's Name: _____ Insured's Social Security #: _____ ID #: _____

Insured's Birthdate: ___/___/___ Relation: _____ **Insured's Employer:**_____

Insurance Address:_____
Street/ PO Box City State Zip

Secondary Dental Insurance Co. Name: _____ Phone#: (____) _____

Insured's Name: _____ Insured's Social Security#: _____ ID#: _____

Insured's Birthdate: ___/___/___ Relation: _____ Insured's Employer: _____

Insurance Address: _____
Street/ PO Box City State Zip

Dental History

Are you currently in pain? **Yes / No**

How is your current dental health? **Excellent Good Fair**

How often do you floss? _____ Brush? _____

Type of bristles on your toothbrush? **Hard Medium Soft**

Have you ever been told to take an antibiotic before treatment? **Yes No**

Would you like fresher breath? **Yes No** Whiter teeth? **Yes No**

Are you happy with the way your smile looks? **Yes No**

If not, what would you change? _____

Do your gums bleed? **Yes No**

Have you had periodontal disease? **Yes No**

Previous/ Present Dentist: _____

Address: _____

_____

Phone number: (____) _____

Date of Last Exam: _____

Date of Last Cleaning: _____

Date of Last X-rays: _____

Would you like our office to request your X-rays? **Yes / No**

If 'no' we will need to take new x-rays.

Other side please →

Medical History (please read)**

PLEASE READ

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive.

Are you under a physician's care now? **Yes No** Physician's name and number: _____

Date of last physical: _____

Have you ever been hospitalized or had a major operation? **Yes No** If yes, please explain: _____

_____

Have you ever had a serious head or neck injury? **Yes No** If yes, please explain: _____

_____

Are you taking any medications, pills, or drugs? **Yes No** If yes, please list: _____

_____

Do you take, or have taken, any osteoporosis medications? **Yes No** If yes, please list: _____

Do you take, or have taken, any blood thinning medications? **Yes No** If yes, please list: _____

Are you on a special diet? **Yes No** _____

Do you use tobacco? **Yes No**

Women Only -Are you: Pregnant? ☐ Trying to get pregnant? ☐ Taking oral contraceptives? ☐ Nursing? ☐

Are you allergic to any of the following? Please circle: YES or NO IF YES, please indicate below.

[ ]Aspirin [ ]Penicillin [ ]Codeine [ ]Acrylic [ ]Metal [ ]Latex [ ]Local Anesthetics [ ]Other, please explain: _____

Please Select your reaction:

[ ] Anaphylaxis [ ] Hives/ Rash

Do you have, or have you had, any following?

Yes No AIDS/HIV Positive
Yes No Alzheimer 's Disease
Yes No Anemia
Yes No Angina
Yes No Arthritis/Gout
Yes No Artificial Heart Valve_____
Yes No Artificial Joint _____
Yes No Asthma
Yes No Atrial Fibrillation
Yes No Blood Disease
Yes No Bruise Easily
Yes No Blood Transfusion
Yes No Blood Thinners
Yes No Breathing Problems
Yes No Cancer _____
Yes No Chemotherapy/Radiation
Yes No Chest Pains
Yes No Congenital Heart Disorder
Yes No Convulsions

Yes No Cortisone Medicine
Yes No Dementia
Yes No Diabetes
Yes No Drug Addiction
Yes No Emphysema
Yes No Epilepsy or Seizures
Yes No Excessive Bleeding
Yes No Fainting/Dizziness
Yes No Frequent Cough
Yes No Frequent Headaches
Yes No Glaucoma
Yes No Heart Attack_____
Yes No Heart Murmur
Yes No Heart Pacemaker
Yes No Heart Trouble/Disease
Yes No Hemophilia
Yes No Hepatitis A, B or C
Yes No Herpes
Yes No High Blood Pressure

Yes No High Cholesterol
Yes No Hypoglycemia
Yes No Irregular Heartbeat
Yes No Kidney Problems
Yes No Leukemia
Yes No Liver Disease
Yes No Low Blood Pressure
Yes No Mitral Valve Prolapse
Yes No Osteoporosis/Penia
Yes No Pain in Jaw Joints
Yes No Parathyroid Disease
Yes No Psychiatric Care
Yes No Parkinson's
Yes No Renal Dialysis
Yes No Rheumatic Fever
Yes No Rheumatism
Yes No Scarlet Fever
Yes No Sickle Cell Disease
Yes No Sinus Trouble

Yes No Spina Bifida
Yes No Stomach Disease
Yes No Stroke_____
Yes No Thyroid Disease
Yes No Tonsillitis
Yes No Tuberculosis
Yes No Tumors or Growths
Yes No Ulcers

Yes No Premedicate/ antibiotics

Have you ever had any serious illness not listed above? **Yes / No** If yes, please explain: _____

_____

PLEASE READ

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status.

AUTHORIZATON:

I give my permission to use my personal health information to carry out treatment, payment, or health care operations. I assign the Doctor all insurance benefits. **I understand that I am responsible for payment at the time of services, any deductible, and co-payment that my insurance does not cover.** I hereby authorize the use of radiographs, dental anesthesia, & generalized dental treatment.

*Patient has the right to review the provider's privacy notice. If you would like to review, or receive a copy of provider's privacy notice, please ask front desk. *

We reserve the right to charge for appointments cancelled or broken without 24 hours advance notice

Signature of patient (or parent/guardian for minor): _____ Date: _____

2512 E. Vistoso Commerce Loop Suite 100
Oro Valley, Arizona 85755
520-797-4844

AUTHORIZATION FOR SIGNATURE ON FILE

Release of information/Financial Responsibility/Authorization for Payment

I, _____ and/or _____
Name of Patient (Parent/Guardian if Minor) Name of insured

hereby authorize the office, Vistoso Dental Partners, along with any associates, to affix my name to any and all dental insurance claims or documents as related to any and all health benefits due me and my dependents.

I hereby authorize payment of dental benefits, otherwise payable to me directly, to the office. I have reviewed the treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan or insurance plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law. I authorize the release of any information relating to the claim.

This "Authorization" will be valid from this date. A photocopy of this document may act as the original

_____ _____
Signature of Insured Date

_____ _____
Signature of Patient (Parent or Guardian if Minor) Date

VISTOSO DENTAL Partners

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

HIPAA Compliance Patient Consent Form Our Notice Of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations
- The practice reserves the right to change the privacy policy as allowed by law
- The practice has the right to restrict the use of information, but the practice does not have to agree to those restrictions
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease
- The practice may condition receipt of treatment upon execution of this consent May we phone, email or send a text to you to confirm appointments?

YES / NO May we discuss your dental conditions with any member of your family?

YES / NO If YES, please name the family members allowed:

_____

_____

_____

Signature: _____ Date: _____

VISTOSO DENTAL Partners

2512 E. Vistoso Commerce Loop Suite 100
Oro Valley, Arizona 85755
520-797-4844

FINANCIAL RESPONSIBILITY

We are committed to providing you with the best possible care. Your clear understanding of our financial and privacy policies is important to our professional relationship.

- Payment is due at the time of service, including co-pay.
- **A (24) hour notice is needed to reschedule an appointment. If a (24) hour notice is not given...a $75.00 service fee will be charged to your account.**
- If insurance is involved, co-pay and any deductible need to be paid at the time services are rendered.
- If your insurance company denies payment for any reason, you will be responsible for the entire bill.
- We will accept Check, MasterCard, Visa, Discover, and Care Credit

It is the patient's responsibility to pay the remaining balance that is not covered by the dental or insurance plans.

If care is being rendered on a minor child, the parent or guardian who accompanies the child to the appointment is financially responsible for the balance on the account.

All treatment plans are estimates only based on information given to us by your insurance company. Any differences between the estimate and what your insurance company pays are your responsibility. Fees are good for (6) months from the date treatment is planned and after that time are subject to change. Posterior composites may not be covered at the same percentage as silver fillings.

I, _____(initials) understand that I may have the following treatment done in office such as: a prophy, exam, xrays, composite fillings, crown & bridge, endodontic treatment, oral surgery and prosthodontic treatment at Vistoso Dental Partners and I give my permission. Initials _____

Signing this does not obligate you to have treatment; it only acknowledges that you received this information.
I understand that I am responsible for all costs of dental treatment regardless of what my insurance carrier may or may not pay on my behalf.

Print: _____ Relationship: _____
PATIENT OR GUARDIAN

Signed: _____ Date: _____
PATIENT OR GUARDIAN

VISTOSO DENTAL Partners

PLEASE FILL OUT TOP PORTION AND MAIL THIS TO YOUR PREVIOUS DENTIST
RELEASE OF RECORDS

Patient Name: _____ **Date of birth:** _____

Previous Dental Office: _____
Address: _____
Phone Number: _____ **Fax Number:** _____
Email: _____
I hereby authorize the above named to send current dental records and release the following information to:

Vistoso Dental Partners
2512 E. Vistoso Commerce Loop
Oro Valley, AZ 85755
520-797-4844 fax: 520-219-0869
Email: info@vistosodentistry.com

_____ _____

Patient Signature **Date**

****TO BE COMPLETED & RETURNED BY PREVIOUS DENTIST****

Will you be sending this info to us via: ☐ Email or ☐ Post Office

Date of last visit to your office: _____

Date of last complete Full mouth xrays: _____

Date of last Panoramic: _____

Date of last series of Bitewings /PAX x-rays : _____

Quad Scaling (which quad & dates mm/dd/yy): _____

Please circle: Prophy D1119 or Perio Maintenance D4910 & date completed: _____

Implant information: Size, brand, type, date placed etc: _____

Dental x-rays: FMX and/or Pano 5 years old and newer, bitewings xrays 2 years old and newer. If x-rays are digital, please email to :

Thank you!