Welcome!

We are pleased to welcome you to our practice. Please take a few moments to fill out this form as completely as possible. If you have questions we'll be happy to help you. We look forward to working with you in maintaining your dental health.

Today's Date:_____

PATIENT INFORMATION

Social Security Number:_____

Home Phone No.:_____
Cellular/Pager No.:_____
Work Phone No.: _____

Mr. / Mrs. / Ms. / Dr. *(circle one)*

Patient Name: _____
Last First Initial Preferred Name

Street Address *(no PO boxes)*: _____ City_____ State_____ Zip_____
E-mail: _____ Sex: ___M ___F Age:____ Birthdate:_____

Single ___Married ___Widowed ___Separated ___Divorced ____

Occupation_____ Patient Employer/School: _____

Employer address: _____

Employer Phone No.: _____

Spouse Name: _____ Birthdate:_____ SS/HC/Patient ID Number:_____

Spouse's Employer:_____ Work Phone:_____

Whom may we thank for referring you?_____

RESPONSIBLE PARTY INFORMATION

Name: Last_____ First _____ Initial_____ Marital Status_____

Mailing Address Street_____ City_____ State_____ ZIP_____

Home Phone:_____ Work Phone:_____ Driver License #_____ State_____

SS/HC/Patient ID#_____ Birthdate:_____ Relationship to Patient:_____

Employer Name & Address:_____ Years Employed:_____

DENTAL INSURANCE INFORMATION

Insured's Name:_____

Insured's Employer: _____

Insurance Co:_____

Address:_____

Insured's SS# or ID#:_____

Group Policy Number: _____

Insurance Co: Phone No:_____

City, State & Zip: _____

IN CASE OF EMERGENCY, CONTACT(RELATIVE NOT LIVING WITH YOU)

Name:_____ Relationship:_____

Home Phone No.:_____ Cell/Pager No.:_____ Work No.:_____

DENTAL AND HEALTH HISTORY

Confidential

Today's Date: _____

Patient Name: _____ Birth date: _____

DENTAL HISTORY

Reason for Today's Visit_____ Date of last dental care_____
Former Dentist_____ Date of last dental x-rays:_____
Address:_____

Mark (X) if you have had problems with any of the following:

___Bad breath
___Bleeding gums
___Clicking or popping jaw
___Food collection between teeth
___Sores or growths in your mouth
___Grinding teeth
___Loose teeth
___Periodontal treatment
___Broken fillings
___Previous orthodontics(braces)
___Sensitivity to hot
___Sensitivity to sweets
___Sensitivity to biting
___Sensitivity to cold

How often do you brush? _____ How often do you floss? _____
Have you been taught how to control dental plaque? _____ Special devices used:_____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____
Have you had any serious illnesses or operations? _____ if yes, please describe_____

Mark (X) if you have or have had any of the following:

___Anemia
___Arthritis
___Artificial heart valve
___Artificial joints
___Asthma
___Bleeding disorder
___Cancer
___Chemical Dependency
___Chemotherapy
___Cortisone treatments
___Cough
___Diabetes
___Epilepsy
___Headaches
___Heart Murmur
___Heart Problems
___Hemophilia
___Hepatitis
___High Blood Pressure
___HIV/ AIDS
___Jaw Pain
___Kidney Disease
___Mitral Valve Prolapse
___Pacemaker
___Pregnant (currently)
___Radiation
___Rheumatic Fever
___Shortness of Breath
___Sinus Problems
___Skin Condition
___Stomach Problems
___Stroke
___Thyroid Problems
___Tobacco Use
___Ulcer
___Other

Details: _____

MEDICATIONS

List Medications Currently Taking:
_____
_____
_____
Pharmacy Name:_____
Pharmacy Phone:_____

ALLERGIES

___Aspirin
___Codeine
___Novocain
___Other _____
___Penicillin
___Sulfa
___Latex

_____

***Medical/Dental Hx Reviewed:**_____**

SIGNATURE

I understand all of the above information is necessary to provide me with dental care in a safe and efficient manner. To the best of my knowledge, the above information is complete and correct. I also understand that it is my responsibility to inform the staff of any changes in my or my minor child's health.

Patient, Parent, or Personal Representative Signature: _____Date:_____

Financial Policy and Explanation of Possible Fees

INSURANCE POLICY
Our office has prepared a letter regarding insurance policy in this office. Please read it and take a copy home for your records. Your signature below indicates you have read and received this letter. A copy will be placed in your dental record.

SIGNATURE ON FILE:
It is important to have a signature on file for any insurance submissions so your insurance will process and pay their portion for services billed to you. You will be given this form to read and sign once a plan of treatment has been presented.

BROKEN APPOINTMENT FEE:
While we understand that unforeseen circumstances may interfere with appointments, please be aware that this office reserves your appointment time especially for you; therefore, A FEE OF $1.00 FOR EACH MINUTE OF SCHEDULED TIME, will be assessed for cancellations of less than 48 hours, no exceptions.

FINANCIAL ARRANGEMENTS
Payment for all treatments less than $250 is expected at the time of service including co-payments. A receipt or statement can be issued for reimbursement accounts. For amounts over $250, financial arrangements are available. A review of the available payment options will be presented and you will be given the opportunity to ask any questions about the aforementioned payment options. A signed financial arrangements agreements document will be completed prior to any treatment being started.

PROMPT PAYMENT
Accounts are considered to be in good standing for thirty days after the billing date. Accounts that are 31-60 days past the billing date are considered past due. Accounts unpaid after 60 days are seriously past due and eligible for a pre-collection action. After this process, the account will be turned over to a collection agency. Please keep your accounts current to avoid any late charges or unnecessary actions or additional fees as indicated below.

LATE CHARGES
If I do not pay the entire new balance within 30 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month. I realize that failure to keep this account current will result in being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs, court costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding balances.

RECORDS REQUEST
As a courtesy to other dental practitioners we are happy to send to or receive from them copies of your dental records including x-rays at no cost. If, however, you choose to pick up or hand carry the records from our office, there is a $35.00 fee to cover duplication and processing costs. There are no exceptions. All records releases require the completion of a release authorization form; no records will be released to you or any other doctor if we do not have this form completed IN ADVANCE- no exceptions.

I have read all of the above policies and understand them.

X_____DATE_____

Signature of Patient or Parent (if minor)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect _____, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0._____ for each page, $_____ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____

_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Eric Lernor,DDS

Telephone: 602-485-4747 Fax: 602-485-0123

E-mail: elernordds@juno.com

Address: 4910 E. Greenway Road, Suite 6, Scottsdale, AZ 85254

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

If you plan to use dental insurance to help pay for your dental treatment, please read, fill out, and sign the next two additional forms and bring the entire packet of completed forms along with your dental insurance ID card with you to your appointment.

To our insured patients:

In order to preserve the best possible relationship with our patients, we hope the following explanation of our position on dental insurance will be helpful.

FILING FORMS: As a courtesy to you, we will be happy to prepare and file the necessary forms for your completed dental treatment. The process of verifying your insurance and following up on claims constitutes a very heavy and costly burden to this office, but we gladly accept this responsibility.

INSURANCE 101: Dental insurance is designed to HELP pay the fee, NOT the entire amount. Please understand that our office does not determine the benefits to be derived under your policy. Insurance is a contract for payment of services you receive between you and your insurance company (negotiated by your employer in your behalf). Because the dentist is not a part of this contract, you, the patient, are responsible for the fees charged for the services received, no matter whether the insurance does or does not provide coverage for a given service. Many plans say you'll be covered up to a certain percentage (like 50%, 80% or even 100%). In spite of what you're told, we've found that many plans cover less than that amount. The benefit your plan pays is largely determined by how much your employer or union paid for the plan. The less they paid for the insurance, the less you'll receive. Therefore, any questions or concerns in regard to covered charges, deductibles, or reimbursement should be referred to your employer or your insurance carrier.

WHAT IS A GOOD DENTAL CONSUMER? Part of being an informed dental consumer is knowing about your policy including the amount a patient may spend per year of the insurance benefits (called the annual maximum), when the insurance goes into effect and when it renews, and what your yearly deductible will be. We urge you to read your policy. Track your dental expenses throughout the year so you can plan for the best use of your dental benefits. Also, know that if you fail to use your benefits during the benefit year, they will be lost. Benefits do not carry over from year to year. **It is your responsibility to notify us PRIOR to any appointments of any insurance changes you have had.**

OUR RELATIONSHIP: The proper relationship between patient, dentist and insurance carrier is often misunderstood. We render to you our best dental care and charge you a fee for that service. Just as the insurance companies do not allow us to set their premium rates, we cannot allow them to set our fees or determine our procedures. These fees are mutually agreed upon between you and me and the insurance carrier does not enter into this relationship. The amount of money paid as reimbursement is a matter between you and the insurance company, and we do not enter into this relationship.

OUR PRIMARY CONCERN IS TO RESTORE YOUR MOUTH TO A STATE OF OPTIMUM DENTAL HEALTH. This implies not only the repair of defective and decayed teeth, but also the proper diagnostic survey of your mouth, involving visual inspection, clinical examination, x-rays and diagnostic study models, to determine the best approach to your dental problem. Unfortunately, not all insurance companies recognize or understand the importance of this type of total dental care, and there may be no allowance in your coverage for these services. **Know that we will do all we can to assure you of receiving the maximum benefits your insurance policy will allow. Do not hesitate to ask me or my staff any questions or concerns you may have in regard to this matter.**

Eric Lernor, DDS

X_____

Patient Signature and Date

INSURED

Authorization for Signature on File

Authorization of payment

I_____ hereby authorized the office of Eric W. Lernor, DDS, to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my employment with _____.

I hereby authorize payment of dental benefits otherwise payable to me, directly to the office of Eric W. Lernor, DDS. This "signature on File" will be valid from this date and shall expire in one year. A photocopy of this document may act as an original.

_____ _____

Signature of Insured Date

PATIENT

Authorization for Signature on File

Release of Information/Financial Responsibility

I_____hereby authorize the office of Eric W. Lernor, DDS, to affice my name to any and all claims or documents as related to any and all health benefits due me. I have reviewed the flowing treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit 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 release of any information relating to this claim. This "Signature on File" will be valid from this date and shall expire in one year. A photocopy of this document may act as an original.

_____ _____

Signature of Insured Date