DENTAL ART

BRUCE A. SPIGNER, D.D.S.

PATIENT INFORMATION

Date: / /

Name_____ Birthdate _____S.S.#_____
HM PHONE_____ CELL PHONE_____WK PHONE_____
HOME ADDRESS _____
CITY_____ STATE_____ ZIP_____
EMPLOYER_____ OCCUPATION_____
Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D ☐ W (IF MARRIED) SPOUSE'S NAME_____
SPOUSE'S CONTACT NUMBER_____ ☐WK ☐CELL

GUARDIAN

NAME_____HM PHONE_____
CELL PHONE _____ WK PHONE_____
ADDRESS_____STATE_____ZIP_____
Legal Guardianship Papers ? ☐ YES ☐ NO (Copy Attached) Does Patient live with you ? ☐YES ☐NO
Group HM_____ Group HM Address_____
Group HM Contact_____ GH#_____

EMERGENCY CONTACT

Outside of Immediate Family/Household
IN CASE OF AN EMERGENCY WHO MAY WE CONTACT ?_____
HM PHONE_____CELL PHONE _____ WK PHONE_____
ADDRESS_____STATE_____ZIP_____

FINANCIAL RESPONSIBILITY

PERSON RESPONSIBLE FOR ACCOUNT: ☐ Patient ☐ Father (or Husband) ☐ Guardian ☐ Mother (or Wife)
Name_____Birthdate_____S.S.#_____
RELATIONSHIP TO PATIENT _____
LEGAL GUARDIAN___ (COPY ATTACHED) CONTACT NUMBER_____
HM PHONE_____ CELL PHONE_____WK PHONE_____
BILLING ADDRESS_____
CITY_____ STATE _____ ZIP_____
EMPLOYER_____OCCUPATION_____

METHOD OF PAYMENT

Responsible party currently has an account with this office
☐ YES ☐ NO
☐ Payment in Full at each appointment (cash or personal check)
☐ Payment in Full at each appointment ☐ Visa ☐ MC
Card#_____ Exp Date:_____
☐ I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGE
If I do not pay the entire balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of $3.00 for a balance under $200.00), which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

SIGNATURE_____(GUARDIAN/PARENT IF MINOR) DATE_____

As a courtesy, we will accept payment of benefits directly from your insurance company.
Please fill this part out accurately and completely.

PATIENT NAME_____DATE_____

PRIMARY DENTAL INSURANCE

INSURANCE COMPANY NAME _____ GROUP # _____
ADDRESS _____
CITY_____ STATE_____ ZIP_____ PHONE_____
Subscribers Name _____ Subscribers Birthdate _____
Subscribers S.S.#_____ Drivers License#_____
ID# _____ RELATIONSHIP TO PATIENT_____
HM PHONE_____ CELL PHONE_____WK PHONE_____
BILLING ADDRESS_____
CITY_____ STATE _____ ZIP_____
EMPLOYER_____OCCUPATION_____
CITY_____ STATE _____ ZIP_____

STUDENT STATUS

IS PATIENT A FULL TIME STUDENT ? ☐ YES ☐ NO ☐ SCHOOL I.D. ATTCHED
SCHOOL NAME_____
ADDRESS_____
CITY_____STATE_____ ZIP_____

SECONDARY DENTAL INSURANCE

INSURANCE COMPANY NAME _____ GROUP # _____
ADDRESS _____
CITY_____ STATE_____ ZIP_____ PHONE_____
Subscribers Name _____ Subscribers Birthdate _____
Subscribers S.S.#_____ Drivers License#_____
ID#_____RELATIONSHIP TO PATIENT _____
HM PHONE_____ CELL PHONE_____WK PHONE_____
BILLING ADDRESS_____
CITY_____ STATE _____ ZIP_____
EMPLOYER_____OCCUPATION_____
CITY_____STATE_____ ZIP_____

Authorization

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as they may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge . I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

SIGNATURE_____(GUARDIAN/PARENT IF MINOR) DATE_____

Print Name_____Witness _____

A Referral...is the highest honor a business can receive from a customer.....

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

If not referred how did you hear about our office ? _____

INITIAL CLINICAL EXAMINATION

Name:	Name you wished to be called:
Patient Account Number:	Date:

Initial Concern: _____

Date of last Dental Visit	Date of last Dental Cleaning	Date of last X-Rays

1. Do you have any dental problems now?. . . . . ☐Yes ☐No

2. Do you have any teeth sensitive to hot or cold? . . ☐Yes ☐No
   Sweets?. . . .. ☐Yes ☐No

3. Have you ever had?
   a. orthodontic treatment (braces). . . . . ☐Yes ☐No
   b. oral surgery? . . . . . ☐Yes ☐No
   c. periodontal treatment(gum surgery)? . . . . ☐Yes ☐No
   d. your teeth ground or bite adjusted? . . . . . ☐Yes ☐No
   e. worn a bite plate or other appliance?. . . . . ☐Yes ☐No

4. Have you noticed loosening of your teeth?. . . . . ☐Yes ☐No

5. Does food tend to become caught between teeth? ☐Yes ☐No

6. Do you suffer from pain/swelling of gums?. . . . . ☐Yes ☐No

7. Do your gums often bleed when you brush?. . . . ☐Yes ☐No

8. Have your parents experienced gum disease?. . . ☐Yes ☐No

9. Problems of the jaw: Have you ever experienced:
   a. clicking of the jaw? . . . . . ☐Yes ☐No
   b. pain (joint, ear, side of face?). . . . . ☐Yes ☐No
   c. difficulty opening or closing mouth?. . . . ☐Yes ☐No
   d. difficult in chewing? . . . . . ☐Yes ☐No

10. Habits: Do you:
   a. Clench or grind your teeth?. . . . . ☐Yes ☐No
   b. Bite your lips or cheeks regularly?. . . . . ☐Yes ☐No
   c. Hold foreign objects with your teeth such as pencils, pens, nails?. . . . . ☐Yes ☐No
   d. Mouth breath while awake or asleep? . . . . . ☐Yes ☐No
   e. Do you snore? . . . . . ☐Yes ☐No

11. Do you feel nervous about having dental treatment? . . . . . ☐Yes ☐No

12. Have you ever had an upsetting experience in a dental office?. . . . . ☐Yes ☐No

13. Do you expect to eventually lose your teeth?. . . . . ☐Yes ☐No

14. Are you dissatisfied with the appearance of your teeth? . . . . . ☐Yes ☐No
   The alignment?. . . . . ☐Yes ☐No
   The color?. . . . . ☐Yes ☐No

15. Is there anything about dental treatment that bothers you?

Please explain: _____

_____

_____

_____

_____

Patient Signature: _____ Date: _____

Consent:
The undersigned herby authorizes Doctor to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection (name of patient) _____ and further authorization and consent that Doctor choose and employ such as assistance as deemed fit. I also understand the use of anesthetic agents and embodies a certain risk. I understand that responsibility for payment of dental services provided in this office for myself or my dependants is mine, due and payable at time services are rendered unless financial arrangements have been made. I further understand that a 1.75% finance charge will be added to any balance over 60 days. In the event of default I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient Signature: _____ Date: _____ Witness: _____

Parent or Responsible Party: _____ Relationship to patient: _____

HEALTH HISTORY

1. Are you having pain or discomfort at this time?..... **YES** NO
2. Have you been a patient in the Hospital during the past two years?..... **YES** NO
   If yes, please list:_____
   _____ **YES** NO
3. Have you been under the care of a medical doctor during the past two years?..... **YES** **NO**
   Date of your last visit: _____ / _____ / _____ Reason for last visit: _____
   Physician's Name:_____ Phone: (____) _____
   Address: _____ Fax: (____) _____
   City: _____ State: _____ Zip Code: _____
4. Are you now taking any medication, drugs, herbs or pills?..... YES NO

MEDICATIONS

5. List any medications you are currently taking and the correlationg diagnosis:

_____
_____
_____

7. Do you take, or have you taken Phenphen or Redux?..... ☐ YES ☐ NO
8. Have you lost more than 10 pounds in the past year?..... ☐ YES ☐ NO
9. Are you on a special diet?..... ☐ YES ☐ NO
10. Do you take, or have you taken a Bisphosphonate such as Fossmax, Boniva, Actonel, Zometa, Aredia?..... ☐ YES ☐ NO

ALLERGIES

6. Are you allergic or have you reacted adversely to any of the following substance?..... YES NO

Aspirin	Nembutal/Seconal	Novicaine or Xylocaine
Barbiturates (sleeping pills)	Penicillin	Tetracycline
Darvon	Other Antibiotics	Percodan
Codine	Latex	Erythomycin
Demerol	Iodine	Scopolamine
Nitrous Oxide	Sulfa	Valium
Other Antibiotics	Local Anesthectic	Acryllic

Other:_____
_____

11. INDICATE WHICH OF THE FOLLOWING YOU HAVE HAD OR HAVE AT PRESENT CIRLCE "(YES) OR (NO)" TO EACH ITEM.

*Artificial Heart Valves	YES NO	Chronic Cough	YES NO	Mental Retardation	YES NO
*Artificial Joints (hip, knee, etc.)	YES NO	Cortisone Medicine /Treatments	YES NO	Muscular Dystrophy	YES NO
*Congenital Heart Disease	YES NO	Diabetes	YES NO	Multiple Sclerosis	YES NO
*Heart Murmur	YES NO	Down Syndrome	YES NO	Pacemaker	YES NO
*HearSurgery	YES NO	Drug Addiction	YES NO	Pain in Jaw Joints	YES NO
*Lupus	YES NO	Ephysema	YES NO	Psychiatric Treatment	YES NO
*Mitral Valve Prolapse	YES NO	Epilepsy or Seizures	YES NO	Radiation Therapy	YES NO
*Organ Transplant	YES NO	Fainting or Dizzy Spells	YES NO	Respiratory Disease	YES NO
*Rheumatic Fever	YES NO	Glaucoma	YES NO	Scarlet Fever	YES NO
*Rheumatic Heart Disease	YES NO	Hay Fever	YES NO	Sickel Cell Disease	YES NO
*Shunt, Graft Or Fistula	YES NO	Heart Failure	YES NO	Shortness of Breath	YES NO
		Hepatitis A (infectious)	YES NO	Sinus Trouble	YES NO
A.I.D.S	YES NO	Hepatitis B (Infectious)	YES NO	Skin Rash	YES NO
Allergies or Hives	YES NO	Hepatitis C	YES NO	Spinal Cord Injury	YES NO
Angina Pectoris	YES NO	Herpes	YES NO	Stroke	YES NO
Back Problems	YES NO	Hemophilia /Bleed Easily	YES NO	Thyroid Problems	YES NO
Blood Transfusion	YES NO	High Blood Pressure	YES NO	Tuberculosis	YES NO
Bruise Easily	YES NO	H.I.V. POSITIVE	YES NO	Ulcers	YES NO
Cancer	YES NO	Jaundice	YES NO	Venereal Disease	YES NO
Cerebral Palsy	YES NO	Jaw Pain	YES NO	Yellow Jaundice	YES NO
Cold Sores / Fever Blisters	YES NO	Joint Replacement	YES NO		
Chemotherapy	YES NO	Kidney Trouble	YES NO		
Circulatory Problems	YES NO	Liver Disease	YES NO		
Cosmetic Surgery	YES NO	Nervousness	YES NO		

OTHER:_____
_____

12. Do you have or have you had any disease, condition or problem not listed?..... YES NO
    IF YES, PLEASE EXPLAIN BELOW:_____
    _____

13. HEIGHT:	WEIGHT:

14. When you walk up stairsor take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?..... ☐ YES ☐ NO
15. Do Your Ankles swell during the day?..... ☐ YES ☐ NO
16. Do you use more than two pillows to sleep?..... ☐ YES ☐ NO
17. Do you ever wake from sleep and feel short of breath?..... ☐ YES ☐ NO
18. Has your medical doctor ever said you have cancer or a tumor?... ☐ YES ☐ NO

Pharmacy Name:_____Phone: (_____)_____

FOR WOMEN ONLY:

Are you pregnant?..... ☐ NO ☐ YES, What month? _____
If yes, when is your due date?_____ Are you Nursing? ☐YES ☐ NO
Are you trying to get pregnant?..... ☐ NO ☐ YES, How Long? _____
Are you taking hormones?..... ☐ NO ☐ YES, Name of Medication? _____
Taking birth control pills?..... ☐ NO ☐ YES, Name Of Medication? _____

Note: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills.Consult your physician / gynecologist for assistance regarding additional methods of birth control.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. If I have any changes in my health status or if my medications change, I shall inform the dentist and team at the next appointment without fail.

Patient (Responsible Party/Guardian) Signature: X _____

Bruce A. Spigner, D.D.S

926 East McDowell Road, Suite 120

Phoenix, Arizona 85006

602.253.0994

Financial Policies

In order to enhance communication and promote understanding regarding this office's Financial Policies, please read through the information. After reading, please provide your signature at the bottom indicating that you fully understand these policies. This form must be signed in order to proceed with your scheduled appointment. If you have any questions or concerns, please ask to speak with the Office Coordinator. Thank you!

- **Insurance:** We are happy to bill both primary and secondary insurances as a courtesy for our patients. It must be understood that each patient is ultimately responsible for the cost of services rendered. We will do our best to estimate accurate insurance coverage and patient portions due; however, the contractual agreement is between you and your insurance company. If the insurance company does not pay the full amount anticipated, the patient is responsible for the difference. Payment would be expected within 30 days of receiving a statement.
- **Patient Payment:** The patient portion due for services rendered is expected at the time of service unless previous arrangements have been made with the office coordinator. We accept cash, checks, money orders, and all major credit cards.
- **Financing:** We have financing options available through Care Credit. If you have an interest in these options, please consult with the office coordinator prior to the date of scheduled treatment.
- **No Shows/ Missed Appointment:** We request notice to cancel or reschedule an appointment at least **48** hours in advance. If appropriate notice is not given, a charge of $65 may be assessed to the patient's account. For appointments scheduled longer than 1 hour, an additional $50 will be charged for each hour missed. For an example: $115 will be charged for a missed/ last minute cancelled for a 2 hour appointment.
- **Refunds for Unfinished Treatment:** If a patient decides to discontinue treatment after it has been started a full refund will not be given. Individual circumstances may be discussed with the office coordinator/dentist.
- **Credits on an Account:** If an insurance company pays more than anticipated creating a credit for the patient, we are happy to either refund the patient or leave the credit on the account to be applied toward future treatment.
- **Balances:** Balances unpaid after 30 days from the date of billing are subject to a financial charge at a rate of 3% per month.
- **Collections:** On occasion, after repeated attempts to collect a balance due, we may need to turn an account over to a collections agency. Should this occur, it is agreed that the financial party listed below shall pay all finance charges, collection cost, and attorney fees and any other costs that may be incurred to enforce collection of any amount outstanding.
- **Returned Checks:** A $35 fee will apply for all checks returned for insufficient funds or closed accounts, and may prevent us from accepting checks as a form of payment for your dental treatment in the future.

I acknowledge that I have read the above information and have been provided with an opportunity to ask questions about its content. I accept full financial obligation for the services I agree to receive by the dental professionals at Dental Art.

Patient Name Printed: _____

Financially Responsible Person: _____

Signature of Financially Responsible Person: _____ Date: _____

DENTAL ART

Insurance Providers

We would like to extend a warm welcome to you and look forward to providing you with excellent service. We have provided a short list of the most common insurances we accept. Please note we do accept others that may not be listed. It is important you understand your dental insurance policy as there are many varieties and coverage types. We would be happy to assist you better understand your policy by answering any questions you may have. Together we can maximize your insurance benefits to fit your dental needs.

Aetna
Assurant Health
Aon Dental Solutions
Careington PPO
Cigna
Delta Denta PPO
United Concordia

Please do not hesitate to call 602.253.0994 with any questions you may have or to schedule an appointment.

DENTAL ART

COMFORT MENU

Name: _____ **Date:** _____

Your comfort is important to us. Our goal is to delivery extraordinary dentistry in a comfortable caring environment.

What do you prefer?

During your appointments:

___ Neck Pillow ___ Blanket ___ Music ___T.V

Preferred form to contact you:

___ Cell ___ Email ___ Home Number ___ Work number ___ Text
Email Address: _____

Sedation Preference:

___ N20(Laughing Gas) ___ Oral Sedation (pill) ___ Twilight Sleep
___ Deep Sedation ___ Hospital Sedation

Appointment Preference (Availability)

___ A.M ___ P.M ___ Mid- day

Music Preference:

___ Country ___ Rock ___ Jazz ___ Oldies ___ R&B ___ Classical
___ Classic Rock ___ Alternative ___ HitList ___ 70's ___ 80's
___ 90's ___Pop ___ Latino ___ Gospel ___ Rap ___Kidz Only

Cable Preference

___ ESPN ___ Comedy Central ___ Lifetime ___ Disney ___ CNN
___ CSPAN ___ BET ___ News ___ Discovery ___ Food Network
___ Animal Planet ___ Travel Channel

We also have a selection of DVD movies you can enjoy during your visit!!!

___ Comedy ___ Drama ___ Action ___ Romance ___SCI- FI ___ Musical

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Acknowledgement of Receipt of Notice of Privacy Practices

****You may refuse to sign this acknowledgement****

If the patient is under 18 years of age, a parent or legal guardian must sign.

I, _____, have received a copy of this offices Notice of Privacy Practices.

Signature: _____

Date: _____

For patients who need pre-medication only:

I am authorizing this office to call me and remind me to take my pre-medication before my dental appointment. They may leave me a message for me regarding this information at any number that I have supplied them. They may leave a message on any answering machine, voice mailbox or whoever answers the telephone. I also authorize this office to remind me of my pre-medication on any post card remainders that the office mails to me.

Signature: _____

FOR OFFICE USE ONLY

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

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Patient reviewed Privacy Practices but elected not to take a copy home
- ☐ Other: _____

Employee Signature: _____

Date: _____

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Personal Health Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: ____/____/____

Release of Information

[ ] I authorize the release of any and all information including diagnosis, financial and dental records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____
[ ] Child(ren) _____
[ ] Other _____
[ ] **Information is not to be released to anyone.**

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell number: _____
If unable to reach me:
[ ] please leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

The best time to reach me is (day) _____ between (time)_____.
I understand that this office will try to accommodate my wishes about my contact information, but may have to contact me at the other numbers if unable to contact me at my requested number/location.

Signed: _____ Date: _____