REGISTRATION AND TREATMENT

I give you my permission to:

text appointment reminders Y N

email appointment reminders Y N

Initials:__________

Date____________________

Home Phone (_____)____________________

Cell Phone (_____)____________________

PATIENT INFORMATION

Name ____________________ (Last Name) ____________________ (First Name) ____________________ (Middle Initial)

SS/HIC/Patient ID #____________________

Address ____________________ E-mail ____________________

City ____________________ State ____________ Zip ____________

Sex ☐ M ☐ F Age______ Birthdate ______________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Patient Employer/School ____________________ Occupation ____________________

Employer/School Address ____________________ Employer/School Phone (_____)____________________

Whom may we thank for referring you?____________________

In case of emergency who should be notified? ____________________ Phone (_____) ____________________

PRIMARY INSURANCE

Person Responsible for Account ____________________ (Last Name) ____________________ (First Name) ____________________ (Middle Initial)

Relation to Patient ____________________ Birthdate ____________ ID#/Soc. Sec. # ____________

Address (If different from patient's)____________________ Phone (_____) ____________________

City ____________________ State ____________ Zip ____________

Person Responsible Employed By ____________________ Occupation ____________________

Business Address____________________ Business Phone (_____) ____________________

Insurance Company____________________

Contract #____________________ Group #____________________ Subscriber #____________________

Names of other dependents covered under this plan ____________________

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name____________________ Relation to Patient ____________ Birthdate ____________

Address (if different from patient's) ____________________ Phone (_____) ____________________

City ____________________ State ____________ Zip ____________

Subscriber Employed by____________________ Business Phone (_____)____________________

Insurance Company ____________________ Soc. Sec. #____________________

Contract #____________________ Group #____________________ Subscriber #____________________

Names of other dependents covered under this plan ____________________

Please Complete Above Information and Next Page

(Vers.D2SSS04)

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DENTAL HISTORY

Reason for Today's Visit ______________________ Date of last dental care ______________________

Former Dentist ______________________ Date of last dental X-rays ______________________

Address ____

Check (✓) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? ______________________ How often do you brush? ______________________

MEDICAL HISTORY

Physician's Name ______________________ Date of Last Visit ______________________

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe ______________________

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates ______________________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS
List medications you are currently taking:

____

____

ALLERGIES

____

____

AUTHORIZATION

I certify that I, and/or my dependent(s), have insurance coverage with ______________________ and assign directly to
Name of Insurance Company(ies)

Dr. ______________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______________________ Signature of Patient, Parent, Guardian or Personal Representative

______________________ Date

______________________ Please print name of Patient, Parent, Guardian or Personal Representative

______________________ Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

Important Information Regarding Dental Insurance

& Financial Responsibility

Thank you for choosing us as your dental care provider. We are committed to providing you with quality care. In order to reduce potential confusion and misunderstandings, we have adopted the following policies concerning insurance and your financial responsibility. We ask that you read and sign it prior to the commencement of any treatment.

- Your insurance policy is a contract between you, the responsible party, and the insurance company.
- Patients are responsible for providing our office with current and valid information including: changes in insurance employer, responsible party, ID numbers, home address and phone numbers.
- We can only bill insurance coverage for procedures on the specific date they are performed.

Contracted Insurance

As a courtesy, our office will file claims for with your dental insurance company. We are only contracted as and "in-network" provider with **Delta Dental, Cigna and Humana**. Please know that each dental plan has different coverage for each employer. They do not always cover the same services. Be aware that insurance coverage may change at the beginning of each benefit year.

Non-Contracted Insurance

We will file claims for any PPO insurance plan, if you have BCBS of AZ, we will bill your insurance and the patient will be responsible for all fees at the time of service. BCBS will reimburse you directly. We do not accept HMO or DMO insurance. We will collect any estimated portions, paid at time of service, and bill your insurance in your behalf. Any out of network fees will be your responsibility.

Insurance Benefits & Patient Responsibility

We expect you to be familiar with your benefits. We use the information you provide us to confirm eligibility, benefits and assist you in estimating future treatment plans. We are not responsible for how your insurance company handles its claim or for what benefits they pay on a claim. We can only assist you in estimating your portion of cost of treatment. *We at no time guarantee what your insurance will or will not pay or do with each claim.* In the event your insurance determines a service to be "not covered", or covered at a lesser amount than estimated, you will be responsible for the complete charge. Deductibles and co-insurances will be deducted from total benefits paid. Visits to specialist offices (i.e. endodontists, oral surgeons, periodontists) and the charges incurred there will affect the amount of benefits available to the patient. Your maximum coverage amount will be reduced with each visit depending on the amount the specialist files to insurance. However, it isn't always possible for us to get this information. Please keep this in mind when reviewing your treatment estimates.

Any claims still outstanding after 90 days become the patient's responsibility. A statement will be forwarded to you with the amount you owe and will be due upon receipt. This office is not responsible for disputing insurance company decisions regarding coverage.

I HAVE CARFULLY READ THE INFORMATION ABOVE.

____ ________________________

Patient or Patients Representative's Signature Date

Office Policies

PLEASE READ CAREFULLY AND SIGN

APPOINTMENTS & SCHEDULING

We appreciate our patients for being on time and keeping their scheduled appointments. Existing scheduled appointments are considered confirmed and must be cancelled at least 24 hours in advance. We understand when emergencies arise. However, please give us a call so that we can use the cancelled appointment time to treat other patients. If not done, we reserve the right to charge a **$50 missed appointment fee.** Also, understand that three consecutive missed appointments may result in dismissal from the practice.

Patients are responsible for knowing when their appointments are scheduled. Reminder calls prior to appointments are a courtesy. If the patient is late by 15 minutes or more, we will most likely reschedule the appointment for two reasons. First, adequate time may not be available to treat the patient properly. Second, the scheduled patients for the rest of the day will run late. In this case, we reserve the right to charge a **$50 missed appointment fee.** **It is highly recommended that the patient schedule their return visit for preventative care at the time of their appointment**.

TREATMENT AND X-RAYS

Due to HIPPA privacy laws and regulations, only patients are allowed back in the treatment area for appointments. Family members and friends are to wait in the lobby. Also, children under the age of 18 must have a parent present for any treatment rendered.

X-rays are very important diagnostic tools for the dentist. Therefore, each new patient will have a panoramic or full mouth x-ray and bitewings taken. Most insurance will cover a full mouth x-ray once every 3-5years and bitewings at least once a year. If these x-rays have been taken at a previous dental office, those x-rays must be brought or mailed to our office by the appointment time. If not, x-rays will be taken on the day of the appointment at the financial responsibility of the patient. A panoramic x-ray is $101 and bitewings are $56.

MEDICAL HISTORY & MEDICATION

All patients must update their provider with any changes in medical history including medication changes.

PREMEDICATION NOTICE: If there is a change in medical history with regard to pre-medication status, we must have a copy of the change documented and signed by the patient's physician. For the patient's protection, treatment will not occur until this change is documented.

Pain Medication (narcotics) will not be prescribed over the weekend.

PATIENT INFORMATION, TREATMENT PLANS, AND RETURNED CHECKS

It is the patient responsibility to inform our office about any changes to insurance, place of employment, address and phone number as soon as possible. Please call us prior to the appointment if insurance has changed to allow us time to verify insurance. Appointments will be delayed until insurance can be verified. If insurance cannot be verified on the day of the appointment, the patient will be responsible for our office fees. Reimbursement, if any, comes from the patient's insurance and will come to the patient directly.

Treatment plan estimates will be given to the patient to review and sign. Please keep in mind that these are ESTIMATES ONLY. Once insurance is billed, if there is a remaining balance, the **patient is responsible for the balance.**

All checks must have a current printed address and home phone number (no P.O. boxes). If not, we require a photocopy of patient identification. A $25 fee will be charged for returned checks. In the event the patient's account is turned over to collections, the patient agrees to pay interest charges.

BY SIGNING, THE PATIENT ACKNOWLEDGES RECEIPT AND FULLY UNDERSTANDS OUR OFFICE POLICIES

SIGNATURE:____________________________________ **DATE:** _______________

Patient Consent Form

PLEASE READ CAREFULLY AND SIGN

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I give Stacey Zittel, DDS, PC permission to use any pictures/photographs and/or x-rays for identification and diagnostic purposes and as a reference for dental labs.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this ______ day of ____, 20_______.
Print Patient Name: ____.
Relationship to Patient: ____.
Signature:____.

PRACTICE NAME: Stacey Zittel, DDS, PC
ADDRESS: 4530 E Ray Road, Suite 180
Phoenix, AZ 85044