COPPER HILLS DENTAL

Welcome

Seth Skinner, DDS
Keith Farr, DDS

795 S. 20th Ave.
Safford, Arizona 85546

T: 928-428-2570
F: 928-428-9460
www.copperhillsdental.com

The benefits of a healthy, happy smile are immeasurable! Our main goal is to help you achieve and maintain your maximum oral health and a smile you are proud to show off. Please fill out this form as completely as possible. We want to make sure we are well informed about your medical history, current medications, and any other factor that might affect your dental health and treatment. The better we communicate, the better we are able to take great care of you.

ABOUT YOU

Today's Date: _____ How did you hear about us? _____

Name (First, Middle, Last): _____

I prefer to be addressed as: _____ Circle One: **Male** **Female**

Birthdate: _____ Age: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Employer: _____ Occupation: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Circle One: **Single** **Married** **Widowed** **Divorced** **Separated** **Partnered**

Spouse's Name: _____

Spouse's Birthdate: _____ SS#: _____

Spouse's Employer: _____ Occupation: _____

When and where are the best times to reach you? _____

Other Family Members Seen by Us: _____

EMERGENCY CONTACT (Please specify someone who does not live in your household).

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

DENTAL INSURANCE

Person Responsible for Account (If other than yourself): _____

Do you have dental insurance coverage? **Yes** **No**

Dental Insurance Co. Name: _____

Dental Insurance Co. Address: _____

City: _____ State: _____ Zip: _____

Dental Insurance Co. Phone: _____

Group # (Plan, Local, or Policy#): _____

Insured's Name: _____ Relationship: _____

Insured's Birthdate: _____ SS#: _____

Insured's Home Phone: _____ Alt. Phone: _____

Insured's Employer: _____ Occupation: _____

ACKNOWLEDGEMENTS & SIGNATURES

I acknowledge that the information I give in this form is correct to the best of my knowledge, and I understand that this information will be held in the strictest confidence. I also understand that it is my responsibility to inform this office of any changes in my insurance or medical status.

I understand that I am required to pay for any dental services provided. In the situation where my insurance plan does not pay for a portion or all of a procedure, I acknowledge that I am responsible to pay in full for that procedure.

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign benefit payment directly to the doctor (even if otherwise payable to me) for service rendered. I understand that a finance charge may be applied for any balance that goes beyond 90 days.

Signature: _____

Date: _____

MEDICAL HISTORY

Do you have a physician? **Yes** **No** Physician's Name: _____ Phone: _____

Date of Last Physical: _____ Current Physical Health: **Excellent** **Good** **Fair** **Poor** **Very Poor**

Are you currently under the care/supervision of a physician? **Yes** **No** Please Explain: _____

Are you currently taking any prescription medications? **Yes** **No** **Please list medications with correlating diagnosis:** _____

_____

For Women: Are you currently taking any oral contraceptives (birth control pills)? **Yes** **No** Are you pregnant? **Yes** **No** Are you nursing? **Yes** **No**

Do you or have you ever used tobacco in any form? **Yes** **No** If yes, how much? _____ For how long? _____

ALLERGIES - Circle any and all of the following to which you are allergic:

Aspirin • Barbiturates/Sleeping Pills • Codeine • Dental Anesthetics • Erythromycin • Ibuprofen/Motrin • Jewelry/Metals • Latex • Percocet • Penicillin • Tetracycline • Vicodin

Please list any other medications and/or materials to which you think you are allergic: _____

COPPER HILLS DENTAL

Seth Skinner, DDS
Keith Farr, DDS

795 S. 20th Ave.
Safford, Arizona 85546

T: 928-428-2570
F: 928-428-9460
www.copperhillsdental.com

MEDICAL CONDITIONS

Have you ever had any of the following medical conditions? **Circle "Yes" or "No"**

Abnormal Bleeding	**Yes**	**No**	Frequent Headaches	**Yes**	**No**	Mitral Valve Prolapse	**Yes**	**No**
Alcohol or Drug Abuse	**Yes**	**No**	Glaucoma	**Yes**	**No**	Pacemaker	**Yes**	**No**
Anemia	**Yes**	**No**	Hay Fever	**Yes**	**No**	Psychiatric Problems	**Yes**	**No**
Arthritis	**Yes**	**No**	Heart Attack	**Yes**	**No**	Radiation Treatment	**Yes**	**No**
Artificial Bones/Joints/Valves	**Yes**	**No**	Heart Murmur	**Yes**	**No**	Rheumatic/Scarlet Fever	**Yes**	**No**
Asthma	**Yes**	**No**	Heart Surgery	**Yes**	**No**	Seizures	**Yes**	**No**
Blood Transfusion	**Yes**	**No**	Hemophilia	**Yes**	**No**	Shingles	**Yes**	**No**
Cancer/Chemotherapy	**Yes**	**No**	Hepatitis	**Yes**	**No**	Sickle Cell Disease/Traits	**Yes**	**No**
Colitis	**Yes**	**No**	Herpes/Fever Blisters	**Yes**	**No**	Sinus Problems	**Yes**	**No**
Congenital Heart Disease	**Yes**	**No**	High Blood Pressure	**Yes**	**No**	Sleep Apnea	**Yes**	**No**
Diabetes	**Yes**	**No**	HIV or AIDS	**Yes**	**No**	Stroke	**Yes**	**No**
Difficulty Breathing	**Yes**	**No**	Hospitalized for Any Reason	**Yes**	**No (If yes, please explain below.)**			
Emphysema	**Yes**	**No**	Kidney Problems	**Yes**	**No**	Thyroid Problems	**Yes**	**No**
Epilepsy	**Yes**	**No**	Liver Disease	**Yes**	**No**	Tuberculosis	**Yes**	**No**
Fainting Spells	**Yes**	**No**	Low Blood Pressure	**Yes**	**No**	Venereal Disease	**Yes**	**No**

Please explain any serious medical conditions you have ever had:

DENTAL HISTORY

Why have you come to our office today?_____ Are you in pain? **Yes** **No** If yes, for how long? _____

Previous Dentist: _____ Phone: _____ Last Visit Date: _____

What was done? _____ Date of Last Cleaning: _____ Date of Last Dental X-rays: _____

Have you ever been told that you require antibiotics before dental treatment? **Yes** **No**

Do you have or have you ever had any of the following conditions, ailments, or treatments? **Circle "Yes" or "No"**

Bad Breath	**Yes**	**No**	Food Collection Between Teeth	**Yes**	**No**	Pain Around Ear	**Yes**	**No**
Bleeding Gums	**Yes**	**No**	Foreign Objects in Mouth	**Yes**	**No**	Pain When Brushing	**Yes**	**No**
Blisters on Lips or in Mouth	**Yes**	**No**	Grinding Teeth	**Yes**	**No**	Periodontal Treatment	**Yes**	**No**
Broken Fillings	**Yes**	**No**	Gums Swollen or Tender	**Yes**	**No**	Sensitivity to Cold	**Yes**	**No**
Burning Sensation on Tongue	**Yes**	**No**	Jaw Pain	**Yes**	**No**	Sensitivity to Heat	**Yes**	**No**
Chew on Only One Side	**Yes**	**No**	Jaw Fatigue	**Yes**	**No**	Sensitivity to Sweets	**Yes**	**No**
Clenching of Teeth	**Yes**	**No**	Lip or Cheek Biting	**Yes**	**No**	Sensitivity When Chewing	**Yes**	**No**
Clicking or Popping of Jaw	**Yes**	**No**	Loose Teeth	**Yes**	**No**	Snoring	**Yes**	**No**
Dry Mouth	**Yes**	**No**	Orthodontic Treatment	**Yes**	**No**	Sores or Growths in Mouth	**Yes**	**No**

Have you ever had a serious/difficult problem associated with any previous dental work? **Yes** **No**

Do you ever experience pain in your jaw joint (TMJ/TMD)? **Yes** **No**

How would you classify your current dental health? **Excellent** **Good** **Fair** **Poor** **Very Poor**

On a scale of 1-10, how would you rate your smile (10 being the best)? _____ Would you like whiter teeth? **Yes** **No**

Would you like straighter teeth? **Yes** **No** What else about your smile would you like to change? _____

Do you feel anxiety about dental treatment? **Yes** **No** On a scale of 1-10, how would you rate your anxiety (10 being the most anxious)? _____

On average, how many times a day do you brush? _____ How many times a week do you floss? _____

What type of bristles does your toothbrush have? **Soft** **Medium** **Hard**

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 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 (10/13/03), 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 $2.00 for each page, $15.00 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 alterative 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 alterative 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.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You May Refuse to Sign This Acknowledgement ****

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

Practices.

Name of Patient (or parent if under 18 years)

_____

Patient Name (printed)

_____

Signature of Patient (or parent if under 18 years)

_____

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
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

COPPER HILLS DENTAL

928-428-2750

Appointment Policy

Copper Hills Dental will work with you to schedule appointment times that are convenient for you. We do not overbook patients in anticipation of no/show or last minute cancellations therefore it is important that you keep scheduled appointments. We understand that last minute changes in your schedule may be unavoidable and we will try to accommodate those changes if possible. However, when appointments are scheduled our dentist's and/or hygienist's time is reserved for you and is unavailable to other patients who need to schedule an appointment. Broken appointments add to the cost of providing care for all patients.

We strive to see patients on time for scheduled appointments; however there are times when our schedule is delayed in order to accommodate an emergency or complication. Please accept our apology should this occur during your appointment.

We attempt to remind patients by telephone, text messaging and email of upcoming appointments. If we are unable to reach you, your reserved appointment time will serve as confirmation of your appointment and implies your obligation to be present. Your acceptance of a scheduled appointment serves as a contract for services with Copper Hills Dental. When appointment is scheduled, we ensure that our professional staff is reserved and an operatory is prepared for your specific appointment requirements. We reserve the right to charge for office visits cancelled or broken without 24 hours advance notice. This notification is imperative to allow us time to schedule another appointment during this time slot. Our standard office policy regarding broken appoints are as follows:

Broken Appointments: Notations will be placed in the patients' record to indicate that an appointment has been broken. The patient may be charged a broken appointment fee of $50.

Patients with a pattern of broken appointments or who miss their first appointment: When patients exhibit a pattern of appointment abuse by failing to show for multiple appointments, future appointments will only be scheduled with a non-refundable deposit up to the cost of treatment planned. The patient's record will be flagged and the patient will be charged a missed appointment fee. If the patient does not wish to pay the missed appointment fee, the patient may not be scheduled for future appointments. Copper Hills Dental will provide dental care, however the patient will be placed on a wait list and will be seen on a space available basis.

Any questions about this policy should be addressed to our office manager or Dr. Skinner.

Thank you for your cooperation

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY PRACTICE'S POLICY.

Date:_____Signed:_____