Sapphire DENTAL CARE

Manoj Sharma, DDS

PATIENT INFORMATION

Patient Information

Full Name _____ Nickname _____ Date _____
Address _____ City _____ Zip _____
Home # _____ Work # _____ Birthdate _____
Mobile # _____ Social Security # _____
Occupation _____ E-mail Address _____
Whom may we thank for referring you to our office? _____
Would you prefer appointment reminders via e-mail (rather than postcards)? ☐ Yes ☐ No
If full-time student, name of school: _____ Marital Status _____

Person Responsible for Account

Full Name _____ Birthdate _____ Drivers Lic # _____
Address _____ City _____ Zip _____
Home # _____ Work # _____ Social Security # _____
Employer _____ Relationship to Patient _____

I accept full responsibility for payment of dental services for the patient named under "Patient Information", due and payable at the time services are rendered. Please see "Office Policies" page for more information.

Signature _____ Date _____

Dental Insurance Information

Subscriber Name _____ Birthdate _____ Subscriber ID # _____
Ins. Company _____ Union Local # _____ Group # _____
Ins. Address _____ City _____ State _____ Zip _____
Ins. Phone _____ Insured Employer _____
If you have dual insurance coverage, please complete the following:
Subscriber Name _____ Birthdate _____ Subscriber ID # _____
Ins. Company _____ Union Local # _____ Group # _____
Ins. Address _____ City _____ State _____ Zip _____
Ins. Phone _____ Insured Employer _____

Dental Information

Are you having any pain or discomfort at this time? Yes No
Do your gums bleed: when you floss? ☐ Yes ☐ No when you brush? ☐ Yes ☐ No
Are your teeth or jaw sore in the morning? ☐ Yes ☐ No
Do you grind or clench your teeth? ☐ Yes ☐ No
Your tooth/teeth are sensitive to: ☐ Heat ☐ Cold ☐ Biting ☐ Sweets
Former Dentist & location: _____
Date of last dental visit? _____ What was performed? _____
What do you dislike about your mouth: ☐ Color ☐ Crowding ☐ Breath ☐ Metal fillings ☐ Nothing

Medical Information

If you have been hospitalized, when & why? _____

If you have been under the care of a physician in the past 2 years, why? _____

Physician's Name _____ Phone #_____

Address _____

Date of your last complete physical exam: _____

Please list all current medications: _____

_____

Please list all substances you are sensitive or allergic to (i.e. latex, antibiotics): _____

Have you ever used tobacco products? ☐ Yes ☐ No

Do you currently use tobacco products? ☐ Yes ☐ No

Person to notify in case of emergency _____ Phone #_____

Have you lost or gained more than 10 pounds in the past year? ☐ Yes ☐ No

Have you ever required antibiotic premedication for dental visits ? ☐ Yes ☐ No

For women only, check if yes: ☐ Pregnant (what month? ____) ☐ Nursing

Check which of the following you previously had or currently have:

☐ Allergies or Hives	☐ Diabetes	☐ High Blood Pressure	☐ Radiation Therapy
☐ Anemia	☐ Epilepsy or Seizures	☐ High Cholesterol	☐ Recreational Drug Use
☐ Arthritis	☐ Fainting or Dizzy Spells	☐ HIV	☐ Rheumatic Fever
☐ Artificial Heart Valve	☐ Glaucoma	☐ Kidney Disease	☐ Sinus Trouble
☐ Artificial Joints	☐ Heart Disease or Attack	☐ Liver Disease	☐ Stroke
☐ Asthma	☐ Heart Murmur	☐ Anxiety	☐ Thyroid Problems
☐ Bacterial Endocarditis	☐ Hemophilia	☐ Pacemaker	☐ Tuberculosis
☐ Chemotherapy	☐ Hepatitis	☐ Shortness of breath	☐ Ulcers

Please state any condition not listed _____

Signature _____

FUTURE MEDICAL UPDATES

Changes:

Signature _____ Date _____

Changes:

Signature _____ Date _____

Changes:

Signature _____ Date _____

Changes:

Signature _____ Date _____

Manoj Sharma, D.D.S.

Getting to know you…

Patient Name _____ Date_____

"Our promise is to provide you the opportunity for a dental experience that meets or exceeds your expectations in a caring, comfortable, and professional atmosphere. We will provide you preventive care to enhance your smile, improve and maintain your dental function, and help you to prevent future dental problems."

To help us serve your dental needs best, we would like to know more about you. Please take a moment to complete the following questions:

What do you expect from your visit with us today?

What is most important to you about your dental health?

On a scale of 1 – 10 (10=highest), how do you rate your dental health & why?

What would you like your teeth to be like in 10 or 20 years?

Are you aware that there are medical conditions related to dental disease?

What do you know about periodontal disease?

If you could improve anything about your smile what would that be?

Are there foods you enjoy but cannot eat due to discomfort with your teeth?

Do you experience any apprehension before or during dental visits? If so, please explain.

Please feel free to let us know how we can help make your dental experience with us more pleasant.

For interoffice use only:

OFFICE POLICIES
Manoj Sharma, D.D.S.

Our philosophy is to provide the highest quality of patient education and dental care to all of our patients. To ensure you begin with a positive experience we have prepared the following information for your review. Please feel free to let us know if you have any questions or concerns.

EXPECTED PAYMENT
To keep our fees to you as low as possible, we ask that payment be made at the time of service. For your convenience you will be provided an estimate for services in advance of your appointment/s to ensure you opportunity to plan in advance for your dental care. We believe whether you privately pay or have dental insurance to assist you, everyone deserves the care they need and want.

_____
Initials

DENTAL INSURANCE
We are happy to file your dental claims to assist you in receiving the full benefits of your coverage. We request you familiarize yourself with your insurance benefits, and provide us the correct information to assist you with the submittal of claims. We will accept the estimated insurance payment directly from your insurance company provided payment is received from them within 45-60 days. Please remember, your insurance is a contract between you, your employer, and the insurance company; therefore, we cannot guarantee coverage. Not all services are covered benefits in all contracts; therefore, you are ultimately responsible for the total amount of your dental fees. The treatment recommended for you is indicated regardless of your dental insurance benefits, deductibles, limitations, or maximums.

_____
Initials

PAYMENT OPTIONS
For your convenience we provide a variety of payment options to help you receive the quality care you need to enjoy a healthy and confident smile. *Please identify which form of payment is most convenient for you at the time of service.*

Cash/Check ___ MasterCard___ Visa ___ Other___ Extended Payment ___ (Please see below)

Please Note: A $25.00 NSF fee will be charged for all returned checks. Should you desire a monthly payment plan we invite you to complete a simple finance company application. There are no application fees or a down payment and the loan can be interest-free.

PAST DUE BALANCES
If applicable balances owing from a prior visit where insurance is not pending, or an insurance payment has not been received within 90-days, or the account has been sent to collections is considered past due. Payment of any past due balance is required to be paid in full before incurring new charges. All balances over 60-days are subject to a $10.00 rebilling fee.

_____
Initials

CANCELLATIONS
If you are unable to keep an appointment that has been reserved for you we request you provide us with a 48-hour advance courtesy notice. Early notification ensures that we can offer you a more convenient appointment and allows us sufficient time to accommodate the needs of another patient therefore filling the time previously reserved for you. We realize that emergencies do occur and we will be flexible under those circumstances.

_____
Initials

CELL PHONES
We ask that cell phones and pagers be turned off at all times while in the treatment area. If being available for an emergency during your reserved appointment please leave our office telephone number so you can be reached. Should an unfortunate emergency arise we would be happy to notify you in the treatment area immediately.

_____
Initials

INFORMATION CHANGES
To ensure your records are current please notify us of any changes related to medical history, telephone number/s, address, employer or insurance information as they occur.

_____
Initials

My signature indicates that I understand that policies as outlined and any questions I have with regard to office policies have been answered.

_____ _____
Signature of Responsible Party or Patient Date

My signature indicates that I have reviewed the office policies with the responsible party and/or patient.

_____ _____
Signature of Staff Member or Doctor Date

Dental Office Policy

Your Privacy - HIPAA Practices

Manoj Sharma, DDS

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 July 1, 2006, 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 $0.75 for each page, $25.00 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 July 1, 2006. 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 Office Manager
Telephone: 623.547.0011
Fax: 623.547.0333
Address: 5220 N. Dysart Rd. #108 Litchfield Park, AZ 85340

I have read and acknowledge the terms of this privacy notice.

_____
Signature

_____
Print Name

_____
Date