Mobile Dentistry of Arizona

P: 480-313-3310
F: 480-772-4032
Scheduling@MobileDentistryofAZ.com

INSTRUCTIONS FOR PATIENT FORMS

It is easy to become a new patient of ours. We have provided new patient forms for your convenience. Please fill them out as completely as possible.

Please include copies of the Medical and Financial Power of Attorney (POA) documents.*

*If the person being seen is Self-Governed and makes all of their own choices about treatment, consent, scheduling, and/or pays their own bills, you do not need to include Medical and Financial Power of Attorney (POA) documents.

CHECKLIST OF COMPLETED FORMS	
	Patient Information Form with Signature and Date
	Dental History/Medical History Form with Signature and Date
	Protecting Your Confidential Health Information with Signature and Date
	Consent to Release of Medical History with Signature and Date
	Copy of Medical Power of Attorney Legal Document with Seal (if applicable)
	Copy of Financial Power of Attorney Legal Document with Seal (if applicable)
	Copy of Dental Insurance Card
	Medication List

FAX FORMS BACK TO: 480-772-4032

Your community can assist you in completing and faxing these forms.

After receiving your forms we will contact you to answer any questions and schedule an appointment. If you have an urgent need please feel free to call 480-313-3310.

For the following questions, please dial 480-313-3310 and the indicated extension:

New Patient Inquiries and Scheduling	**Ext. 101 or Ext. 109**
Billing and Insurance	**Ext. 103**
Clinical Questions and Emergencies	**Ext. 100**

Mobile Dentistry of Arizona is a unique private practice that provides a high standard of care to all patients regardless of age or geographic location. Our patients are our family, and are treated with respect, compassion and gentleness. Thank you for allowing us to care for you and your family!

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Patient Information Only

Patient Name:_____
Last First MI Nickname

Date of Birth:____/____/_____ **SSN:**_____ **Marital Status:** S M Other **Sex:** M F

Patient Living Address:_____
Street City State Zip Code

Patient Phone:_____ **Patient Email Address:**_____

Who referred you to us?_____

Dental Insurance Information

Insurance Company:_____ **Group #:**_____
Name

_____
Insurance Billing Address Insurance Phone Number

Subscriber Name:_____ **Relationship to Patient:**_____

Subscriber SSN or ID#:_____ **Subscriber DOB:**____/____/_____

Subscriber's Employer:_____ **Employment Status:**_____

Employer Address:_____
Street City State Zip Code Phone

Responsible Party / Power of Attorney Contact Information

Medical POA

Name:_____

Relation to Patient: **(Check all that apply)**
☐ **Family** _____ ☐ **Power of Attorney** ☐ **Friend** ☐ **Self**

Home Phone:_____

Cell Phone:_____

Work Phone:_____

Address:_____

_____

Email Address:_____

Signature:_____

Financial POA ☐ Check here if same as Medical

Name:_____

Relation to Patient: **(Check all that apply)**
☐ **Family** _____ ☐ **Power of Attorney** ☐ **Friend** ☐ **Self**

Home Phone:_____

Cell Phone:_____

Work Phone:_____

Address:_____

_____

Email Address:_____

Signature:_____

I assign insurance benefits to be paid directly to Mobile Dentistry of Arizona.
I authorize the use of my signature on all insurance applications and credit card/debit card transactions.
I understand that I am financially responsible for any and all charges of dental treatment and incurred fees and I agree to pay such charges in full.

X _____
MUST BE SIGNED HERE **Patient / Responsible Party / Power of Attorney** **Date**

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Dental History

Patient Name:_____
Last First MI Nickname

Previous Dentist:_____ **Phone:**_____

Date of last dental appt:____/____/_____ **Last X-rays:**____/____/_____ **Last Cleaning:**____/____/_____

Do you have a: Denture Yes___ **No**___ **Partial Yes**___ **No**___ **Implants Yes**___ **No**___

Medical History - *Required for Appointment*

Primary Care Physician:_____ **Phone:**_____

Y or **N** DNR Initial:_____

Please Circle One:

Y or **N** Are you currently being treated by a physician?

- If yes, what are you being treated for? _____

Y or **N** Are you taking medications? A current list of medications will be required for a dental visit.

Y or **N** Any recent hospitalizations? List: _____

Y or **N** Allergic to any medications? List: _____

Y or **N** Are you allergic to latex?

Y or **N** Do you have any **artificial joints**? (Knees, hips, etc) Placement/Surgery Date: ____/____/_____

Y or **N** Have you ever had a **heart valve replacement**? Date: ____/____/_____

- Pre-medication will be required prior to dental appt for all heart valve replacements and/or new joints 2 years old or less.

Y or **N** Do you take aspirin? Frequency: _____ Dosage: _____

Y or **N** Do you take any blood thinners? (I.e. Coumadin, Plavix, etc) List:_____

Y or **N** Have you ever taken medications for Bone Replacement? (Fosamax, etc.) List:_____

Y or **N** Do you use tobacco products? _____

Y or **N** Have you ever been diagnosed with oral cancer? Date: ____/____/_____

Y or **N** Have you ever been diagnosed with Alzheimer's Disease? Early Stage: ___ Moderate Stage: ___ Advanced Stage: ___

Y or **N** Have you ever been diagnosed with Dementia? Early Stage: ___ Mid Stage: ___ Late Stage: ___

Do you use a: Scooter___ Walker___ Are you able to transfer to a dental chair? **Y** or **N**

Please check all conditions that apply

☐ AIDS/HIV	☐ COPD	☐ High blood pressure	☐ Seizures
☐ Alzheimer's/Dementia	☐ Depression	☐ Low blood pressure	☐ Stroke
☐ Anxiety/Nervous disorder	☐ Diabetes	☐ Mitral valve prolapse	☐ Swollen feet/ankles
☐ Bleeding gums/ Gum disease	☐ Grinding teeth	☐ Osteoporosis	☐ Tuberculosis
☐ Blindness	☐ Headaches	☐ Oxygen use	☐ Weight loss (sudden)
☐ Cancer (type)	☐ Hearing loss	☐ Parkinson's	☐ Other: _____
☐ Chronic pain	☐ Heart disease	☐ Radiation treatment	_____
☐ Congestive Heart Failure	☐ Hepatitis	☐ Respiratory disease	_____

I certify that the above information about my medical history is accurate. I authorize and give consent for my dentist to perform dental services agreed upon as well as discuss dental care with my PCP.

➡ **X** _____

MUST BE SIGNED HERE **Patient / Responsible Party / Power of Attorney** **Date**

X _____

Dentist **Date**

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CONSENT TO RELEASE OF MEDICAL HISTORY

This authorizes all medical facilities, physicians and medical attendants to furnish any and all of my medical reports, history and information to Mobile Dentistry of Arizona, or to any representative of Mobile Dentistry of Arizona, concerning my medical condition. This authorization also includes examination of all medical facilities records, x-ray films, past and current medications and furnishing of any information including opinions.

You are further requested not to disclose such information to any other person without written authority to do so.

The attending caregiver(s)/nursing staff are allowed to have information to help with my oral care and its instructions.

_____YES _____NO

I also give written authority to release information to:

_____ _____

Person / Relation - Please Print | Type of information (Scheduling, Treatment, Billing, All)

_____ _____

Person / Relation - Please Print | Type of information (Scheduling, Treatment, Billing, All)

_____

Patient Name - Please Print

_____

Patient Signature / Power of Attorney Signature and Title (Medical POA, Financial POA)

_____

Address | City | State | Zip

_____

Date

MUST BE SIGNED AND RETURNED

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HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT STATEMENT (HIPAA)

I intend for my agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individuality identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Title 42 United States Code Section 1320d and 45 Code of Federal Regulations Sections 160-164.

When in the process of determining my incapacity, all individual identifiable health information and medical records may be released to the person(s) nominated as Health Care Agent under my Health Care Power of Attorney, or Attorney-in-Fact under Durable General Financial Power of Attorney to include any written opinion about my incapacity that the person so nominated may have requested, even if that person has not yet been appointed as my agent. I also request from this day forward under any and all circumstances to release all individually identifiable health information and medical records to **Mobile Dentistry of Arizona**.

I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, any insurance company and the Medical Information Bureau Inc. or other health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking payment from me for such services to give, disclose and release to **Mobile Dentistry of Arizona**, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, to include all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness and drug or alcohol abuse.

The authority given to **Mobile Dentistry of Arizona** shall supersede any prior arrangement that I may have made with my health care providers to restrict access to or disclosure of my Individually Identifiable Health Information. The authority given to **Mobile Dentistry of Arizona** has no expiration date and expire only in the event that I revoke the authority in writing and deliver to my health care provider.

_____

Client Name / Power of Attorney (print)

_____ ____/____/_____

Signature Date