Mobile Dentistry of Arizona

P: 480-313-3310
F: 480-772-4032
patientcare@mobiledentistryofarizona.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.

If the person that needs an appointment makes their own decisions, fills out their own paperwork, and pays their own bills, they would be considered SELF-GOVERNED. If this is not always true, a power of attorney will need to be listed.

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 for 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 (if applicable)
	Medication List

Fill the new patient forms out online at
www.mobiledentistryofaz.com
or FAX FORMS BACK TO: 480-772-4032
secure email: patientcare@mobiledentistryofarizona.com

After receiving your forms we will contact you to finalize details and schedule an appointment.

Please call our office for scheduling questions at 480-313-3310 and use the appropriate extension:

NEW PATIENT INQUIRIES & SCHEDULING APPOINTMENTS:
EAST Valley cities and Tucson: EXT. 1
WEST Valley cities and Prescott: EXT. 2

BILLING AND INSURANCE QUESTIONS: EXT. 3

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 care.

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

Name of Community: _____ **Community phone only:** _____

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:**_____

Responsible Party / Power of Attorney (POA) Information

Medical POA

Name:_____

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

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 Governed**

Home Phone:_____
Cell Phone:_____
Work Phone:_____
Address:_____
_____
Email Address:_____
Signature:_____

Patient or POA please initial:

_____ I authorize _____ to assist myself (poa) with medical decisions and or financial decisions for _____ (patient)
_____ I authorize the use of my signature on all insurance applications and credit card/debit card transactions.
_____ I agree to pre pay for all dental services that are approved by the patient/payee/power of attorney. 3.5% processing fee will apply to all debit/credit card transactions. Dental claims will be filed as a courtesy and reimbursement will be sent directly to the insured.
_____ I agree to pay a $75 travel fee for each dental appointment and may vary depending on location and zip code.
_____ I understand that a $95.00 fee will be assessed for all broken appointments within 48 hours of the agreed upon day and time.
_____ I agree to pay a 3% assessment on unpaid balances over 90 days, continuing each month until the balance is paid in full. (24% annual precentage rate). All returned checks or ach transactions that are insufficent will be assessed a $50.00 fee.
_____ I am aware that approved treatment and treatment plans have no refund.

➡ **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:**_____

Pharmacy:_____ **Phone:**_____

Please Circle One:

Y or **N** Do you have a Do Not Resuscitate Order (DNR) Initial:_____

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** Any other allergies? List: _____

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: ___

Y or **N** Do you use a: Scooter___ Walker___ Wheelchair ___

Y or **N** Are you able to transfer wheelchair to a dental chair?

Per MDOA's safety policy, electric scooters and walkers are not permitted on the medical lift or inside the mobile office.

Please check all conditions that apply

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

I certify that the above information about my medical history is accurate. I authorize and give consent for Mobile Dentistry of Arizona to perform dental services agreed upon as well as discuss dental care with my Primary Care Physician.

X _____

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

X _____

Dentist **Date**

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CONSENT FOR 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.

This authorizes Mobile Dentistry of Arizona dental professionals to use electronic and/or digital communications, and/or teledentistry. I acknowledge the following:

a) The potential for breach of confidentiality, or inadvertent access, of protected health information using electronic and digital communication in the provision of care.

b) The potential disruption of electronic and digital communication.

c) The potential sharing of patient information with involved parties, such as; Patients, Doctors, Nurses, Caregivers, Power of Attorneys, and anyone else who may have access to patient information.

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 First MI Last

_____
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 - Please Print

_____ ____/____/_____

Signature Date

MUST BE SIGNED AND RETURNED