Apache Family Dentistry
100 W. Apache Trail
Suite #1
Apache Junction, Arizona 85120

PATIENT HIPAA CONSENT FORM

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 (HIPAA). 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 Practice, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. 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 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.

Print Patient Name _____

Signature _____

Date _____

DR. TRACEY YAMAMOTO, D.D.S.
APACHE FAMILY DENTISTRY

Thank you for visiting Apache Family Dentistry. Please help us by completing this form in full.

Patient's Name_____
Last First Middle Initial

Home Address_____
Street City State Zip

Home Phone#_____ **Work#**_____ **Cell#**_____

Male ___Female___ Single___ Married___Divorced___ Widowed__Other____

Date of Birth_____ **Patient's Age____ Social Security #**_____

Physician Name_____ **Phone Number**_____

FINANCIAL RESPONSIBILITY if different from above OR if patient is under 18

Legal Guardian _____ **D.O.B**_____

Address_____
Street City State Zip

Home # (___)_____ **Cell # (___)**_____

Employer_____
Name Address Phone #

Dental Insurance_____ **Insurance Phone #**_____
Subscribers Name_____ **SS or ID#**_____
Employer Name_____ **DOB**_____
Group or Plan #_____
Secondary Dental Insurance Company_____

Insurance Authorization Statement (sign and date)
I hereby authorize payment to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for the costs of all dental treatment. We will file your insurance claim as a courtesy to you. In the event that your insurance company does not pay the estimated amount, or does not pay in a timely manner (60 days), it is your responsibility to pay the full fee.

If you do not have insurance, payment is due at the time services rendered.

Signature_____ **Date**_____

Do you or have you ever had?

Y N Abnormal Bleeding
Y N Alcohol Abuse
Y N Allergies
Y N Anemia
Y N Arthritis
Y N Artificial Heart Valve
Y N Asthma
Y N Cancer/ Chemo
Y N Congenital Heart Disease
Y N Diabetes
Y N Drug Abuse
Y N Epilepsy
Y N Excessive Urination/ Thirst
Y N Fainting Spells
Y N Fen Phen/ Redux
Y N Glaucoma
Y N Hay Fever
Y N Hearing Loss
Y N Heart Attack
Y N Heart Disease
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis type___
Y N Herpes
Y N High Blood Pressure
Y N Emotional/ Nervous Disorder
Y N HIV/ AIDS
Y N Immune Suppressed Disorder
Y N Joint Replacement
Y N Kidney Disease
Y N Liver Disease
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Pace Maker
Y N Radiation Therapy
Y N Rheumatic Fever
Y N Seizures
Y N Sexually Transmitted Diseases
Y N Sickle Cell Disease
Y N Sinus Problems
Y N Stent
Y N Stroke
Y N Thyroid Problems
Y N TB or Lung Disease
Y N Tumor/ Malignancy
Y N Tobacco Products
How Often_____
Y N Ulcers
Y N Yellow Jaundice

Y N Do you or have you ever taken Bisphosphonates (Fosamax, Boniva, Aredia, Actonel, Zometa, Etc.)
Y N I usually take an Antibiotic prior to dental treatment. Type_____

Are you ALLERGIC to?

Y N Aspirin
Y N Barbiturate
Y N Codeine
Y N Ibuprofen
Y N Dental Anesthetics
Y N Penicillin
Y N Erythromycin
Y N Tetracycline
Y N Jewelry/ Metals
Y N Latex
Y N Sulfa Drugs Sulfites/Sulfides
Y N Other _____

Are you currently under the care of a physician? Y N
Please explain_____

Please **list the medications** that you are currently taking and explain:

_____

_____

_____

Female Patients: Are you pregnant? Y N How many weeks? _____
Do you take birth control? Y N Are you nursing? Y N

Office Policies

A minimum of 24 hours notice is required to cancel a dental appointment to avoid a $25.00 fee. All payments are due at the time of service.

I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this form is correct to the best of my knowledge.

Patient's signature_____ Date_____