11111 N. Scottsdale Road, Suite #130
Scottsdale, AZ. 85254
480-776-0643
www.bonitadental.com

PATIENT INFORMATION

Name: _________________________________ Today's Date: __________________________ Male Female

Full Address:____ Email:______________________________

Home No:_________________________ Cell No:________________________ Work No:_____________________

Age:________ Date of Birth:______________ Single Married Social Security No:___________________

Occupation:______________________________ Employer:____________________ How long employed?________

Spouse or Parent:________________________ Date of Birth:______________ Social Security No:_____________

Full Address:____

Occupation:____________________________ Employer:____________________ Phone No:___________________

INSURANCE INFORMATION

Insured Person's Full Name:___________________________________ Date of Birth:_________________________

Social Security No:_________________________ Relationship to Patient:________________ Work No:________

Insurance Company Name:____________________________ Group Name:______________ Group No:_________

Employer Name:______________________________ Insurance Company Phone No:__________________________

Full Address of Insurance Company:____

Do you have other dental insurance?____

OTHER INFORMATION

Why did you select Bonita Dental for your dental needs?____

Whom may we thank for referring you?____

Do you have any relatives that are currently, or have been patients of Bonita Dental? __________________________

Person to contact in case of emergency? ____

Relationship:___________________________________ Phone No:____

PERSONAL DENTAL HISTORY

Diana A. Batoon, D.M.D., P.C.
11111 N. Scottsdale Rd., Suite 130
Scottsdale, AZ. 85254
Phone: 480-776-0643 Fax: 480-776-0647 Email: bonitadental@gmail.com

Name: ____ Date: __________________________

What name would you like us to call you? ____

Purpose of today's visit:

____
____
____

Why have you decided to deal with this now?

____

Have you consulted with any other dentist about this? ◯ Yes ◯ No If yes, what was discussed or done?

____
____

When was your last dental & cleaning check up? ____

Previous Dentist? __________________________________

DO YOU NOW HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

Have gum disease (gingivitis)	◯ Yes ◯ No	Food collection between teeth		◯ Yes ◯ No
Grind your teeth	◯ Yes ◯ No	Sores, blisters or growths		◯ Yes ◯ No
Clicking or popping jaw	◯ Yes ◯ No	Bad Breath		◯ Yes ◯ No
Jaw Pain or tiredness	◯ Yes ◯ No	Sesitivity to:	Cold	◯ Yes ◯ No
Pain around ear	◯ Yes ◯ No		Heat	◯ Yes ◯ No
Lip or cheek biting	◯ Yes ◯ No		Sweets	◯ Yes ◯ No
Loose or broken teeth or fillings	◯ Yes ◯ No		Biting/Chewing	◯ Yes ◯ No

WOULD YOU LIKE TO KNOW WHAT OPTIONS ARE AVAILBLE TO YOU TO:

1. Create a more attractive smile ◯ Yes ◯ No
2. Look Younger ◯ Yes ◯ No
3. Keep your teeth for life ◯ Yes ◯ No

WHAT WOULD YOU LIKE TO SEE DONE NOW?

____
____
____

HEALTH HISTORY

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Name: ____________________________________ **Birthdate** ___________________ **Social Security #**__________

Mailing Address: ____

Marital Status: ◯ **Single** ◯**Married** ◯ **Divorced** ◯ **Widowed**
Who may we thank for referring you to our office: ____

Phones: Work: _________________________ **Home:** ______________________________ **Fax:**____________________

Cell: __________________________ **Email:** ____

Occupation: _____________________________ **Employer & Address** ____

Spouse's Occupation:___________________________ **Employer & Address:** ____

Account Responsibility (if someone other than yourself): Name:____

Their Social Security #:_______________________ **Birthdate:**______________________________

Mailing Address:____ **Daytime Phone;** __________________________

Health History (Please check if you have or had any of the		Following)	
◯ Yes ◯ No	Are you in good health?	◯ Yes ◯ No	Diabetes
◯ Yes ◯ No	Has your health changed in the last year?	◯ Yes ◯ No	Cortisone Medicine
◯ Yes ◯ No	Chest pain, shortness of breath	◯ Yes ◯ No	Tumors, Cancer
◯ Yes ◯ No	Bleeding problems, bruise easily	◯ Yes ◯ No	Radiation treatment
◯ Yes ◯ No	Headaches, ringing in ears	◯ Yes ◯ No	Depression
◯ Yes ◯ No	Joint pain or stiffness, arthritis	◯ Yes ◯ No	Kidney or bladder disease
◯ Yes ◯ No	Fainting or seizures	◯ Yes ◯ No	Coldsores, Feverblisters, Herpes
◯ Yes ◯ No	Heart disease, murmurs, rheumatic fever	◯ Yes ◯ No	HIV Positive, AIDS, ARC
	prosthetic heart valve, irregular heartbea	◯ Yes ◯ No	Pregnant: month _______________
◯Yes ◯ No	Pacemaker	◯ Yes ◯ No	Birth Control Pills
◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Recreational drugs: smoking/alcohol
◯ Yes ◯ No	Hepatitis or liver disease	◯ Yes ◯ No	Latex Allergies
◯ Yes ◯ No	TB, asthma or lung disease		

List any and all ALLERGIES: ____
List any and all DRUG/MEDICATIONS you are taking: ____
List any and all SURGERIES: ____
◯ Yes ◯ No Are you being treated by a Doctor now? ____ Who? ____

The above information is true and correct. I authorize Dr. Batoon to use my case and photographs for teaching or promotional purposes.

Patient Signature: ____ Date:________________________

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Financial Policy

PATIENT NAME: ____________________________ INSURANCE COMPANY: __________________

EMPLOYER: ________________________________PERSON RESPONSIBLE FOR ACCOUNT:______________________

FINANCIAL ARRANGEMENTS FOR NON-INSURED PATIENTS

I consent and authorize the indicated dental services to be performed. I understand and agree to pay the fees associated with the dental treatment as indicated below. Bonita Dental is a *Fee For Service Office*. I understand full payment is required on the date services are rendered. I understand that I am responsible for all costs of dental treatment. Acceptable payment methods include:

_____ CASH

_____ CREDIT CARD (Visa, MasterCard, Debit Card, Discover)

Account Number: ____ Expiration Date: ___________________

3-Digit Verification Code _________________

FINANCIAL ARRANGEMENTS FOR INSURED PATIENTS

I understand that is my responsibility to furnish Bonita Dental with correct dental insurance information. I acknowledge, that as a courtesy, Bonita Dental will submit my dental claims and receive all reimbursement. I understand that my dental insurance is a contract between the insurance carrier and myself, not a contract between my dental insurance carrier and Bonita Dental. Any deductible, co-payment, or service not covered in the design of my insurance plan will be billed to me and I agree that I am responsible for the entire balance due, regardless of insurance reimbursement.

I authorize Diana A. Batoon D.M.D. to keep my signature on file and to debit the credit card below for any outstanding balances not paid in full within 60 days of treatment, and not to exceed $1,500.00 per debit.

Account Number: ____ Expiration Date: ____________________

3-Digit Verification Code _________________

Cardholder's Name: _____________________________________ Cardholder's Signature: ____________________

FINANCIAL ARRANGEMENTS FOR OUTSTANDING ACCOUNT BALANCES

I understand that I am responsible for all costs of dental treatment and for all dental fees associated with the treatment. If for any reason I do not pay my entire account balance within 15 days of the monthly billing cycle, a FINANCE CHARGE or BILLING FEE may be applied to my account. The finance charge will be at least 18% of the outstanding balance or a fee of at least $50.00. I understand that in the event of a past due account in which I have not contacted Bonita Dental within 30 days will be considered in default. If my account reaches default status I understand that Bonita Dental will transfer my account to an outside collections agency or attorney. If my account is referred for collection, I will be responsible for all fees and costs included in the transfer. I understand Bonita Dental reports to all three major credit bureaus.

Patient Signature: ____ Date: ____________________________

Print Name: ____

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Appointment Policy

We schedule our dental appointments very carefully to assure all of our patients are seen promptly and that sufficient time is allocated for each procedure. We do this because we value and respect our patient's time and desire to provide the best treatment possible. In order to remain on schedule, we request that you arrive on time for your appointments.

Occasionally, emergencies arise with may cause us to run over into your appointment. Every effort will be made to inform you of this, if the situation arises. We appreciate your understanding, as someday you or a family member may be in need of emergency dental care.

THREE BUSINESS DAYS NOTIFICATION IS REQUIRED TO AVOID A CANCELLATION CHARGE. THE MINIMUM FEE IS $ 75.00 FOR A LATE CANCELLATION OR NO SHOW. We require notification by 4pm Tuesday for appointments scheduled the following Monday.

I have read and understand the appointment policy stated above.

Patient Signature:_________________________________ Date: ______________________

Please print name:_________________________________

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Health Insurance Portability and Accountability Act

All healthcare providers who transmit information in electronic form are required to comply with the Health Insurance Portability and Accountability Act, or HIPPA. The Act contains provisions that cover privacy and security of healthcare information and standardizes transaction codes for dental procedures when submitted for reimbursement by employers or insurance via electronic means.

American Dental Association Member Dentists, and their staff, have been and will continue to be bound by professional standards of confidentiality that are even more stringent then those required by law. We have always taken measures to protect your privacy, and we will continue to do more than is required by law to assure that your privacy is adequately protected.

Our office has a designated Privacy Officer who implements our Privacy Policy. Our Privacy Officer maintains the office records, and copies health information for distribution upon your direction and request. You may add information for us to distribute in writing so long as the information is signed and dated.

We need your consent to distribute three types of information:

1.) Consent for the distribution of information for treatment, payment and health care operations.
2.) Consent for the disclosure of protected health information.
3.) Consent for all other uses of protected health information.

This office requires that all three forms of consent be given so that we may adequately care for you and your family.
We do not disclose or distribute any non-public personal information obtained in the course of practice except as required or permitted by law. Permitted disclosures include, providing information to our employees, dental specialists, or in limited situations, to unrelated third parties who need to know that information to assist us in providing service to you, for example, a dental laboratory, consultant, or administrative professional. In all such situations, we stress the confidential nature of the information being shared on your behalf and direction. Our contracts with our business associates require that they take any necessary steps to ensure your privacy.

Your privacy is important. Thank you for your trust.
I consent to the distribution of public and non-public, protected and non-protected information as necessary for dental treatment, payment and dental health care operations. I authorize the distribution to any and all parties required.

Patient Signature: ___________________________ Date: _______________________________
Print Name: _______________________________

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Consent for Use & Disclosure of Health Information

SECTION A: PATIENT GIVING CONSENT

Name: ____

Address: ____

Telephone No.: ___________________________________ E-mail: ___________________________________

Social Security No.: ____________________________ Date of Birth: ____________________________

SECTION B: TO THE PATIENT

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting our office.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, ______________________________, have had the full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: ____ Date: ____________________

If this consent is signed by personal representation on behalf of the patient, complete the following:

Personal Representative's Name: ____

Relationship to patient: ____

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Consent for Internet Communications

I grant my permission to Diana A. Batoon D.M.D. to upload and store confidential patient information, including account information, appointment information and clinical information to the secured website for Diana A. Batoon D.M.D. I understand that for security purposes the site requires a user I.D. and password for access and use. I also understand Diana A. Batoon D.M.D. and myself are responsible for maintaining the strict confidentiality of any I.D. and password assigned to me; and that Diana A. Batoon D.M.D. is not liable for any charges, damages or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand Diana A. Batoon D.M.D. is not liable for any harm related to the theft of my I.D. and password, my disclosure of my I.D. and password, or my authorization to allow another person or entity to access and use the Diana A. Batoon D.M.D. website with my I.D. and password. I also agree to immediately notify Diana A. Batoon D.M.D. of any unauthorized use of my I.D. or of any other need to inactivate my I.D. due to security concerns. I also understand State and Federal laws, as well as ethical and licensure requirements imposing obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand Diana A. Batoon D.M.D. will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my patient information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that Diana A. Batoon D.M.D. has the right to monitor, retrieve, store, upload and use my patient information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand Diana A. Batoon D.M.D. will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the website on my behalf. I understand Diana A. Batoon D.M.D. CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE WEBSITE OR THE SERVICES.

I have read the information above regarding the secured uploading of patient information to the website for Diana A. Batoon D.M.D. and grant Diana A. Batoon D.M.D. permission to securely upload my patient information to the website.

Patient Name: ______________________________ Date: ____________________

Patient Signature: ______________________________

E-mail Address: ______________________________

I ________________ give permission for Dr. Diana Batoon DMD,PC to show pictures of my smile to patients, potential patients, and for marketing, advertising and educational purposes.

_______________________________   _______________________________

Patient Signature   Today's Date