Sun City West Dental
Dr Chad Achatz
Patient information

Patient Name: _____ Date of Birth_____
Address: _____ Sex: M F
City: _____State: _____Zip: _____
Home Phone: _____Cell Phone: _____
Email: _____

Emergency Contact name: _____Relationship: _____
Phone: _____

Who may we thank for referring you to us for care? _____

Insurance Information:

Primary Coverage

Name of Carrier: _____ Plan/Group #_____

Name of Insured: _____Date of Birth: _____

ID/Subscriber Number: _____

Secondary Coverage

Name of Carrier: _____ Plan/Group #_____

Name of Insured: _____Date of Birth: _____

ID/Subscriber Number: _____

Authorization for Treatment: This is to certify that I, the undersigned Patient or Guardian, consent to all medical procedures agreed to between myself and Sun City West Dental, including the use of local, inhalation, and sedative anesthesia as indicated, and I will assume complete responsibility for all fees associated with those procedures. I agree that all fees are due and payable, in full, at the time services are rendered.

Patient/Guardian Signature: _____ Date: _____

Sun City West Dental
Dr Chad Achatz
Medical/Dental History

Patient Name: _____ Date: _____

Physician's Name: _____ Phone: _____

Last Physical _____ Last Visit with Physician _____

Please tell us if you have any of the following by checking the appropriate conditions:

☐Bacterial Endocarditis	☐Heart Surgery	☐Artificial Replacement	☐Diabetes
☐Heart Murmur	☐Congestive Heart Failure	Knee, hip, joint, pins, plate	☐Kidney Problems
☐Irregular Heart Beat	☐Blood Disease/Problems	☐Premedication required	☐Dialysis
☐High Blood Pressure	☐Excessive Bleeding	☐Neurological Problems	☐Liver Problems
☐Low Blood Pressure	☐Respiratory disease	☐Epilepsy/Seizures	☐Hepatitis (A, B or C)
☐Rheumatic Heart Disease	☐Tuberculosis	☐Malignancies/Chemotherapy	☐Stroke
☐Artificial Heart Valves	☐Eye Disorders/Glaucoma	_____	☐Thyroid Problems
☐Mitral Valve Prolapse	☐HIV/AIDS	☐Cancers, Tumors, Growths	☐Herpes
☐Heart Attack _____ Year	☐Tobacco Use	☐Human Papillomavirus HPV	☐Pregnant _____months
☐Angina/Chest Pain	☐Marijuana use	☐Emotional Problems	☐Oral Contraceptives
☐Heart Pacemaker	☐Radiation treatment	☐Chemical Dependency	
☐Dementia/Alzheimer's	☐Bisphosphonates-Prolia/Boniva		

List any Medical Conditions not listed above:

_____

List all Allergies to Drugs, Medications or Anesthetics:

_____

*******COMPLETE ATTACHED MEDICATION AND SUPPLEMENT SHEET**

Are you interested in whitening your teeth? YES / NO
Are you dissatisfied with your teeth and their appearance? YES / NO
Please Explain _____

Do you presently have:

☐Abscesses in mouth ☐Bad Breath ☐Bad Tastes ☐Bleeding Gums ☐Clenching or Grinding ☐Difficulty Chewing
☐Dry Mouth ☐Gag Easily ☐Infection in Gums ☐Loose Teeth ☐Missing Teeth ☐Stained Teeth
☐Pain in Jaw ☐Sensitive Gums ☐Sensitive Teeth ☐Swelling
☐Unusual noises when eating Other Concerns: _____

Patient/Guardian Signature: _____ Date: _____

Sun City West Dental

Dr. Chad Achatz

Please read the following statements and sign below

Insurance Disclaimer:

Patients that carry dental insurance must understand that all dental services provided are billed to insurance as a courtesy, but the patient is ultimately responsible for the payment of all dental services regardless of dental benefits. The office will provide an "ESTIMATE" of what your insurance will pay based on the information your carrier has provided. Our office will assist in making collection from your insurance company by filing the necessary forms; however, our office is not responsible for any charges the insurance company will not pay. After insurance has processed the claim and payment, any remaining balance will be billed to the patient and is due within 15 days of statement.

Assignment of Benefits:

I hereby authorize payment directly to Sun City West Dental and Dr Achatz. I authorize Sun City West Dental to release any and all medical information concerning treatment performed to my insurance carrier.

Credit policy:

Estimated patient portion of services are due at the time such services are rendered. Sun City West Dental will file appropriate claim forms to my insurance carrier. I will be notified when the final action (payment, denial, etc.) by my insurance carrier is received. I understand if my account becomes delinquent it will be placed for collection with US Collections West. Further, I agree to the following terms regarding any outstanding balance that I owe:

> **I will incur interest at a rate of 1 ½ percent per month (18% per annum); I agree and hereby consent that I will be responsible for collection costs and attorney fees involved in the collection of the account.**

Cancelation policy:

If you find that you must change your appointment, we require a minimum of 48 hours' notice so that we may make every effort to accommodate other patients. If proper notice is not received, a fee may be charged for every appointment cancelled. The standard cancelation fee is $50 per hour of scheduled time.

Printed Name of Patient _____

Signature: _____Date: _____

Sun City West Dental

Dr. Chad Achatz

<u>Privacy Practices:</u>

I understand 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 (HIPPA) I understand that by signing this consent I authorize you too use and disclose my protected health information to carry out:

- **Treatment (including direct or indirect treatment by other healthcare providers.**
- **Obtaining payment from third party payers (e.g., my insurance company).**
- **The day-to-day healthcare operations of the practice.**

I have also been informed of, and given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA.

I understand that I have the right to request restrictions on how my protected information is used and disclosed to carry out treatment, payment, and the health care operations.

I Authorize the following person(s) to be allowed access to my dental records:

Name_____ Relationship_____

Name_____ Relationship_____

I understand I can revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke consent is not affected.

Printed Name of Patient: _____

Signed: _____ Date: _____

Sun City West Dental
13920 W. Camino Del Sol #12
Sun City West, AZ 85375
623-584-7060

For the best in healthcare always carry a medication list

Medication/Supplement	Dosage	Times per day taken

Your care is our concern.