

Kierland Dental Center

Michael R. Thompson, DDS, PC
7102 E. Acoma Dr., Ste #3 * Scottsdale, AZ 85254 * (480) 556-0310

PATIENT INFORMATION

Name: _____ Birthdate: _____ SS#: _____ Sex: M F

Married Widowed Child Single Divorced Phone: (____) ____ - ____ cell home work

Additional Phone: (____) ____ - ____ cell home work E-mail: _____

Is it Ok to contact you regarding appointments by: Email? Y / N Text? Y / N

Address: _____ City: _____ State: _____ Zip: _____

Employer/School: _____ Employer/School Phone: _____

Spouse or Parent's Name: _____ Employer: _____ Phone: _____

Person to contact in case of emergency: _____ Phone: _____

Whom may we thank for referring you? _____

Responsible Party (If different from info above)

Person Responsible for this Account: _____ Relation to Patient: _____ Birthdate: _____

Is responsible party currently a patient in our office? Yes No Phone: _____

Address: _____

E-Mail: _____

Primary Insurance Information

Name of Policy Holder: _____ Birthdate: _____ Relation to Patient: _____

Social Security or ID #: _____ Employer: _____ Work Phone: _____

Insurance Company: _____ Insurance Phone: _____ Group #: _____

Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance

Name of Policy Holder: _____ Birthdate: _____ Relation to Patient: _____

Social Security or ID #: _____ Employer: _____ Work Phone: _____

Insurance Company: _____ Insurance Phone: _____ Group #: _____

Address: _____ City: _____ State: _____ Zip: _____

MEDICAL HISTORY:

Physician's (PCP) Name: _____ Date of last visit: _____

1. Have you taken any BISPSPHONATE drugs? Alendronate (Fosamax), Zoledronate (Zometa), Pamidronate (Aredia), Risedronate (Actonel), Clondronate, Ibandronate, Etidronate (Didronel) ? Yes No
2. Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No
3. Have you been under the care of a medical doctor during the past two years? Yes No
If yes, for what? _____

Physician's Name: _____ Phone #: _____

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4. Have you had any serious illnesses or operations, or hospitalized? _____ Yes _____ No If yes, describe _____

5. (Women) Are you pregnant? _____ Yes _____ No Nursing? _____ Yes _____ No
Taking birth control pills? _____ Yes _____ No

If you are taking birth control pills, please be advised that ANTIBIOTICS may inactivate birth control medication. Therefore, if you are prescribed antibiotics during dental treatment, additional birth control methods should be used until your next menses.

6. Have you ever been advised by a medical doctor to PREMEDICATE with antibiotics prior to dental treatment? _____ YES _____ NO
If yes, please state the reason for premedication: _____

7. Are you aware of having an allergic or adverse reaction to any medication or substance? _____ YES _____ NO
If yes, please list: _____

8. Please circle which of the following you have had, or have at present:

- | | | | |
|------------------------------|-----------------------|-----------------------|----------------------------|
| Anemia | Cough up Blood | High Blood Pressure | Shortness of Breath |
| Arthritis, Rheumatism | Cough, Persistent | HIV/AIDS | Skin Rash |
| Artificial Heart Valves | Diabetes | Jaw Pain | Snoring/Sleep Apnea |
| Artificial Joints, Pins, etc | Epilepsy | Kidney Disease | Stroke |
| Asthma | Fainting | Liver Disease | Surgical Implant |
| Back Problems | Glaucoma | Mitral Valve Prolapse | Swelling of Feet or Ankles |
| Bleeding Abnormally | Headaches | Multiple Myeloma | Thyroid Problems |
| Cancer | Heart Murmur | Osteoporosis | Tobacco Habit |
| Chemical Dependency | Heart Problems | Pacemaker | Tonsillitis |
| Chemotherapy | Hemophilia | Radiation Treatment | Tuberculosis |
| Circulatory Problems | Hepatitis Type: A B C | Respiratory Disease | Ulcer |
| Congenital Heart Lesions | Hernia Repair | Scarlet Fever | Venereal Disease |
| Cortisone Treatments | | | |

ANY DISEASE, CONDITION OR PROBLEM NOT LISTED: _____

NONE OF THE ABOVE.

9. Ear, Nose and Throat ~ Please check which of the following you have had, or have at present:

- | | | |
|--|--|--|
| <input type="checkbox"/> A sore throat that does not heal | <input type="checkbox"/> A white or red patch in your mouth | <input type="checkbox"/> Pain on chewing or opening your mouth |
| <input type="checkbox"/> Difficulty in swallowing | <input type="checkbox"/> Persistent hoarseness | <input type="checkbox"/> Persistent pain in the ear |
| <input type="checkbox"/> Loss of smell, a bloody nasal discharge, or coughing up blood | <input type="checkbox"/> A lump or mass in the neck that does not heal | <input type="checkbox"/> Persistent bad breath |
| | | <input type="checkbox"/> Persistent nasal congestion |

10. Medications – Please list medication taken, prescribing physician, and reason taken.

DENTAL HISTORY:

- Reason for today's visit _____
- Former Dentist: _____ City, State: _____
- Date of last dental care _____ Date of last dental X-rays: _____ Date of last dental cleaning: _____
- What was done at your last dental visit? _____

Patient Name: _____

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5. Check if you have had problems with any of the following:
- | | | |
|--|---|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums when brushing or flossing | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal (gum) treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food Collection between the teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> NONE OF THESE | |
6. How often do you have dental examinations? _____ How often do you floss? _____ How often do you brush? _____
7. Are you satisfied with your teeth's appearance? YES NO
If not, what would you like to change? _____
8. Do you feel nervous about having dental treatment? YES NO
If so, what are your concerns? _____

History Review:

Doctor's Signature: _____ Date: _____

CONSENT:

____ (Initials) To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have change in health. The undersigned hereby authorizes Dr Michael R Thompson to take necessary radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr Thompson to make a thorough diagnosis of the patient's dental needs. I authorize Dr Thompson to perform any and all forms of treatment, medication and therapy that may be indicated in connection with (Name of Patient): _____, and further authorize and consent that Dr Thompson choose and employ such assistance as he deems fit. I further understand that the use of anesthetic agents embodies a certain risk.

Authorization and Release

____ (Initials) I certify that I, and/or my dependent(s), have insurance coverage with (insurance company) _____ assign directly to **Michael R. Thompson, DDS, PC** all insurance benefits, if any, otherwise payable to me for services rendered I authorize the use of my signature on all insurance submissions. The above-named facility may use my health care information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. *I understand that responsibility for payment for services provided in this office for myself and my dependents is mine, due and payable at the time services are rendered, whether or not paid all or in part by my insurance plan.* I understand that it is my responsibility to inform Michael R. Thompson, D.D.S of any changes in my insurance carrier and/or coverage. I understand that I will be responsible for payment in full if my insurance company takes longer than 60-days from the date of service to process my claims when claims have been submitted timely by this office. Any changes that are acquired as a result of not informing Michael R. Thompson, D.D.S of insurance carrier changes are my financial responsibility and must be paid within 60 days of the date of service.

____ (Initials) I further understand that a 1 ½ % finance charge (18% annually) will be added to *any balance over 60 days; including pending insurance claims.* In the event of default, I (We) promise to pay legal interest on indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note. **Payment is due in full at time of treatment unless prior arrangements have been approved.**

Patient Name: _____

Signature of Patient, Parent, Guardian or Personal Representative

Date

Relationship to Patient: _____

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Policy Regarding Missed or Cancelled Appointments

We understand that unplanned issues can come up, and you may need to cancel an appointment. If that happens, we respectfully ask that you call at least 48 hours in advance.

Because of high demand for appointments, missed appointments prevent us from scheduling appropriately and caring for others in need of urgent care.

A FEE WILL BE ASSESSED DEPENDING ON THE LEVEL OF COMPLEXITY FOR ALL MISSED APPOINTMENTS NOT CANCELLED WITH AT LEAST 48 HOURS ADVANCE NOTICE.

Thank you for your cooperation. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

I understand and accept the terms of this policy. Patient name: _____

Patient signature: _____ Date: _____

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THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information (PHI), and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 09/23/2013, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, email and/or text, or letters).

Email: We may use or disclose your health information for purposes of appointments, treatment, coordination of care, and/or electronic copies of your patient records via encrypted and unencrypted E-mail systems to you, or treating specialists. There is some level of risk that third parties might be able to read unencrypted emails. We have an option for you to open a Secure Portal within our HIPAA compliant appointment reminder software/vendor at your request.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- o Prevent or control disease, injury or disability;
- o Report child abuse or neglect;
- o Report reactions to medications or problems with products or devices;
- o Notify a person of a recall, repair, or replacement of products or devices;
- o Notify a person who may have been exposed to a disease or condition; or
- o Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise

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permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. *You must make the request in writing.* You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full. I can withdraw my consent to electronic communications by calling the office.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: Michael R Thompson, DDS, PC **Telephone:** (480) 556-0310 **FAX:** (480) 556-0340

Address: 7102 E Acoma Dr; Ste #3; Scottsdale, Arizona 85254 **E-mail:** officemrtdds@aol.com

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Receipt of Privacy Policies and Practices

I have received and copy of Michael R. Thompson, D.D.S., PC's Privacy Policies and Practices and reviewed them prior to giving consent for release of information and treatment. I understand that I may request in writing to restrict how my private information is disclosed to carry out treatment or for payment by a third-party payer.

Consent for Release of Information:

I understand that, under the Health Insurance Portability & Privacy Act of 1996 (HIPPA), that I have certain rights to privacy in regards to my protected health information. I authorize Michael R. Thompson, D.D.S, PC to release this information to: conduct normal healthcare operations, obtain payment from third-party payers, and plan my treatment and follow up with our healthcare providers.

Signature of Patient or Legal Representative

Date

Patient's Name

Date

Legal Representative Information (if applicable):

Name: _____

Relationship: _____

Address: _____
Street City State Zip

I, _____, give my consent and authorization for Michael R. Thompson, DDS and his staff to discuss and disclose any personal health information regarding my dental treatment and financial matters related to dental treatment to the following person(s):

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

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AUTHORIZATION TO RELEASE DENTAL RECORDS

Today's Date: _____

Patient's Name: _____ **Date of Birth:** _____

To: _____

I request and authorize all records, including xrays, periodontal charting and written notes/treatment pertaining to my care in your office to be emailed to:

info@kierlanddentalcenter.com

If digital copies are not available, mail physical copies to:

Michael R. Thompson, DDS
7102 E. Acoma Dr. Ste. 3
Scottsdale, AZ 85254

Patient/Guardian Signature: _____ **Date:** _____

Disclaimer:

This facsimile transmission contains information, which is confidential and/or privileged. This information is intended for use only by the addressee indicated above. If you are not the intended recipient, please be advised that any disclosure, copying, distribution, or use of the contents of this information is strictly prohibited, and that any misdirected or improperly received information must be returned to this company immediately. Your cooperation in phoning us of erroneous receipt is requested.