JOHN A. GARZA
DDS·LVIF·BSC·PC

754 S Val Vista Dr Ste 106, Gilbert, AZ 85296
Phone: (480) 539-7979
Fax: (480) 539.7977
www.johnagarzadds.com

Date: _____

Patient Information

Sex O M O F

Patient's Name _____

Address _____

City _____

State _____ Zip _____

Home # _____

Work # _____ Cell# _____

Date of Birth _____ Age

Social Security # _____

E-mail _____

O Married O Widowed O Single O Minor
O Separated O Divorced O Partnered for _____ years

Patient Employer/School

Occupation _____

Employer/School Address _____

Employer/School Phone (_____)

Spouse's Name

Spouse's Employer & Phone # _____

Who may we thank for referring you?

_____

IN CASE OF EMERGENCY CONTACT

Name _____

Phone (_____)

Relationship to Patient _____

Please provide identification of responsible party and medical/dental insurance card.

Primary Dental Insurance

Who is responsible for this account? _____ Policy Holder _____

Birth Date _____ SS# _____ Relation to patient: O Spouse O Partner O Child

Employer _____ Employer Phone# _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____ ID# _____

Secondary Dental Insurance

Who is responsible for this account? _____ Policy Holder _____

Birth Date _____ SS# _____ Relation to patient: O Spouse O Partner O Child

Employer _____ Employer Phone# _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____ ID# _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependents(s), have insurance coverage with _____ and assign directly to *Dr. John Garza* all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges regardless of insurance coverage or whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

I consent the above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services. I agree to provide the necessary information needed in determining insurance benefits or the benefits payable for related services. I understand that payment is due at the time services are rendered and any estimated portion from treatment plans are estimates only and are estimated on information obtained by my dental insurance company.

X

Signature Date

Print Name _____

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Dental and Health History

Reason for Today's visit? Questions or Concerns?

Have you been satisfied with dental care received in the past? o Yes o No

Would you like your teeth whiter? o Yes o No

Do you wear any removable dental appliances? (ei, dentures, partials, retainers) o Yes o No _____

Former Dentist _____ **City/State** _____

Date of Last dental visit _____ **Date of last dental X-Rays** _____

Physician's Name & Office Phone _____ **Date of Last Visit** _____

Additional comments or Concerns? _____

_____

Have you ever taken any of the groups of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). oYes oNo

Place a Mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	oYes	oNo	Epilepsy	oYes	oNo	Respiratory Disease	oYes	oNo
Anemia	oYes	oNo	Fainting or Dizziness	oYes	oNo	Rheumatic Fever	oYes	oNo
Arthritis, Rheumatism	oYes	oNo	Glaucoma	oYes	oNo	Scarlet Fever	oYes	oNo
Artificial Heart Valves	oYes	oNo	Headaches	oYes	oNo	Sinus Trouble	oYes	oNo
Artificial Joints	oYes	oNo	Heart Murmur	oYes	oNo	Skin Rash	oYes	oNo
Asthma	oYes	oNo	Heart Problems	oYes	oNo	Special Diet	oYes	oNo
Back Problems	o Yes	o No	Hepatitis Type_	o Yes	o No	Stroke	o Yes	o No
Bleeding abnormally	o Yes	o No	Herpes	o Yes	o No	Swollen Feet or Ankles	o Yes	o No
Blood Disease	o Yes	o No	High Blood Pressure	o Yes	o No	Swollen Neck Glands	o Yes	o No
Cancer	o Yes	o No	Jaundice	o Yes	o No	Thyroid Problems	o Yes	o No
Chemical Dependency	o Yes	o No	Jaw Pain	o Yes	o No	Tonsillitis	o Yes	o No
Chemotherapy	o Yes	o No	Kidney Disease	o Yes	o No	Tuberculosis	o Yes	o No
Circulatory Problems	o Yes	o No	Liver Disease	o Yes	o No	Tumors	o Yes	o No
Congenital Heart Lesions	o Yes	o No	Low Blood Pressure	o Yes	o No	Ulcer	o Yes	o No
Cortisone Treatments	o Yes	o No	Mitral Valve Prolapse	o Yes	o No	Venereal Disease	o Yes	o No
Cough, persistent or bloody	o Yes	o No	Infective Endoarditis	o Yes	o No	Weight Loss, unexplained	o Yes	o No
Diabetes	o Yes	o No	Pacemaker	o Yes	o No	Depression	o Yes	o No
Emphysema	o Yes	o No	Psychiatric Care	o Yes	o No	Other	o Yes	o No
Do you use Tobacco	o Yes	o No	Radiation Treatment	o Yes	o No	Other	o Yes	o No

o Cigars o Cigarettes o Pipe o Chew

Women:

Are you pregnant? o Yes o No

Due Date _____

Birth control pills? o Yes o No

Are you nursing? o Yes o No

Allergies to the following? o NONE

o Aspirin	o Local Anesthetic	o Valium
o Codeine	o Sulfa	o Nitrous Oxide
o Iodine	o Penicillin	o Barbiturates(Sleeping Pills)
o Latex	o Other Allergies	o _____

Medications

List any medications you are currently taking and the reason you take this drug or mark o NONE.

Pharmacy Name

Phone (_____) _____ -

_____

I certify that the information I have entered (personal, dental/medical history or insurance information) is to the best of my knowledge. I also certify and assume legal and financial responsibilities regardless of insurance coverage.

X

Signature _____ Date _____

Print Name _____

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PAYMENT POLICY AND AGREEMENT

IF YOU DO NOT HAVE DENTAL INSURANCE:

- **Payment is due at the time of services rendered, unless prior written arrangements have been made.**
- **No Checks please.** We accept Cash, Visa, MasterCard, American Express, Discover, Debit and Care Credit Cards.
- Financing is available through Care Credit.
- *If there is unpaid balance remaining on the account after a period of sixty days, we reserve the right to begin charging interest on your account at 2% of your unpaid balance per month. There will be a $35.00 charge for all returned checks. If account goes to collections a 66% charge will be added to your account balance.

IF YOU HAVE DENTAL INSURANCE:

- Your insurance is a benefit to you. As a courtesy, we will be happy to assist you in sending forms and coordinating benefits. **However, if payment from the insurance company is not sufficient to pay the balance in full, the patient (and/or insured) is responsible for the remaining balance**. If upon receipt of payment from the insurance company, we find that there has been overpayment of $50.00 or more, we will provide your account with a choice of a refund check or credit balance for that amount. This figure will vary by any deductible amount that has not yet been met.

Divorced Parents:

- If the patients being seen are children from a divorced family, the parent who brings the child to the appointment is responsible for the **entire** payment of services. A receipt will be provided.

FAILED APPOINTMENTS:

- Failed appointments (less than 48 hours notice) are a significant contributor to rising healthcare costs.

Individuals who fail an appointment time reserved for them may be assessed a fee based on the length of the missed appointment. Your appointment time has been reserved just for you. Please arrive ten minutes early, as it may be necessary to reschedule your appointment if you are late. We are committed to being prompt but need your help to stay on schedule. Thank You.

- We make every attempt to remind you of upcoming appointments, either by phone, postcard or e-mail and ask that you please respond back to confirm the appointment time and date.

Your signature indicates your acknowledgement of your responsibility for payment of fees and acceptance of the terms outlined as above.

_____	_____
Name of Patient	Name of Responsible Party
_____	_____
Signature	Date

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Patient Consent

Payment is due as services are rendered. If I have dental insurance I agree to take care of any deductibles or co-payments **at each appointment**.

THE FORM OF PAYMENT IN OUR OFFICE IS DEBIT, CREDIT OR CASH ONLY.

Billing your insurance company is a service we provide as a courtesy to you. Our office will **ESTIMATE** your dental benefits as accurately as possible, but there may be clauses or restrictions that are unknown at this time.

I do understand that it is ultimately my responsibility to know my insurance benefits. Any portion of my treatment not paid by my insurance company is my obligation and **I agree to pay the balance in full within 30 days of all claims being processed.** Any amount still outstanding after 30 days will result in late fee of 2% per month charged to my account. If my account must be referred to small claims court or a collection agency, I agree to pay any court costs and collection fees of 66% in the fair prosecution of the claim. In the future, if there are any changes in your health history or insurance it is your responsibility to inform this office.

THERE WILL BE A $75.00 CANCELLATION FEE CHARGED FOR APPOINTMENTS CANCELLED WITHOUT 48 HOURS NOTICE.

IF 3 APPOINTMENTS ARE MISSED WITHOUT 24 HOURS NOTICE, THIS CAN RESULT IN DISMISSAL FROM THE PRACTICE. RELEASE OR TRANSFER OF RECORDS:

RELEASE OR TRANSFER OF RECORDS:

Originals must be retained in the office, however we can copy records or transfer records for a $25.00 duplication fee.

Consent for Use of Records I hereby give my permission for the use of dental records, including photographs and radiographs, made in the process of examinations, treatment and retention for purposes of professional consultations, research, education, or publication in professional journals.

My signature certifies consent for dental treatment.

Name of Patient

Name of Responsible Party

Signature

Date

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HIPAA FORM

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT:

Name:_____

Section B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

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.

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.

By signing below, you consent for our office to communicate with you via text or email regarding your appointments, treatment, specialist referrals, insurance providers, spouses, and persons of interest using non-secure means.

Print Full Name Below:

_____**, have had 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 a personal representative on behalf of the patient, complete the following below:

Personal Representative's Name Printed: _____

Relationship to the Patient:_____

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UARS/OJA/SLEEP BREATHING DISORDERS

Snoring ☐YES ☐NO
Daytime sleepiness ☐YES ☐NO
Un-refreshing sleep ☐YES ☐NO
Frequent awakenings ☐YES ☐NO
Insomnia ☐YES ☐NO
Gastro intestinal issues ☐YES ☐NO
Attention deficit disorder ☐YES ☐NO
Posture problems ☐YES ☐NO
Dry mouth/ dry throat ☐YES ☐NO
Impotence ☐YES ☐NO
Apneas ☐YES ☐NO
OMD ☐YES ☐NO
Mood swings ☐YES ☐NO
Memory problems ☐YES ☐NO
Mouth breathing ☐YES ☐NO
Lips apart at rest ☐YES ☐NO
Speech abnormalities ☐YES ☐NO
Bed wetting ☐YES ☐NO
Behavior problems ☐YES ☐NO
ADD/ ADHD ☐YES ☐NO
Allergies ☐YES ☐NO
Difficulty swallowing ☐YES ☐NO

TMD/TMJ

Pain ☐YES ☐NO
Where?_____
Hurts to open ☐YES ☐NO
Hurts to close ☐YES ☐NO
Limited opening ☐YES ☐NO
Deviation ☐YES ☐NO

Popping or clicking ☐YES ☐NO
Grinding ☐YES ☐NO

EAR

Competition ☐YES ☐NO
Itching ☐YES ☐NO
Vertigo/ dizziness ☐YES ☐NO
Tinnitus (ringing) ☐YES ☐NO
Decreased hearing ☐YES ☐NO

Neuromuscular/ Physiologic

Headaches ☐YES ☐NO
Migraines ☐YES ☐NO
How often?
_____
_____

Facial pain ☐YES ☐NO
Neck pain ☐YES ☐NO
Botox ☐YES ☐NO
Injury/accident ☐YES ☐NO
Bruxism/clenching ☐YES ☐NO
Comfortable bite ☐YES ☐NO
Difficulty chewing ☐YES ☐NO
Shoulder pain ☐YES ☐NO
Numb hands ☐YES ☐NO
Worn teeth ☐YES ☐NO
Broken dentistry ☐YES ☐NO

COSMETIC BASED ORTHODONTICS

Crowded teeth ☐YES ☐NO
Happy with appearance?
☐YES ☐NO
Lip position/ size ☐YES ☐NO
Happy with facial esthetics?
☐YES ☐NO
Profile ☐YES ☐NO
Nose size ☐YES ☐NO
Cheek bones ☐YES ☐NO

Signature:_____

Date:_____

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HIPAA RELEASE FORM

Patient Name: _____

Privacy regulations require us to have a release signed by our patients so we may speak with family members, friends and other relations regarding your medical treatment and patient financial information. Each person you wish to be considered a contact must be listed individually by name (including a Spouse or Significant Other).

Please print name, relationship and telephone number for each person to whom you are authorizing release of your private health care information and account balances.

Name	Relation	Phone #
Name	Relation	Phone #
Name	Relation	Phone #
Name	Relation	Phone #

Signature:_____

Date:_____