Desert Valley
ORAL SURGERY

Name:	DOB:	Gender: [ ] M [ ] F
Family Status:[ ] Married [ ] Single [ ] Child [ ] Other	Social Security #:	
Address:	City: State: Zip:	
Home Phone:	Cell Phone:	Email:
Who is financially responsible for this patient?		
Emergency Contact Name & Phone Number:		

If we are assisting in filing insurance on your behalf, please provide insurance card & photo ID

Insured (Subscriber) Name:	DOB:	ID#:
Insurance Company:	Employer:	Group #:
I have medicare as a part of my medical insurance coverage? [ ] Y [ ] N		

Whom may we thank for referring you to our practice?	
[ ] Dental Office:	[ ] Friend/Current Patient:

Have you ever had any of the following? Please check all that apply:

[ ] AIDS/HIV	[ ] Depressed Immune System	[ ] Heart Murmur	[ ] Pacemaker
[ ] Allergies	[ ] Diabetes	[ ] Head Injuries	[ ] Radiation Treatment
[ ] Anemia	[ ] Epilepsy	[ ] High Blood Pressure	[ ] Respiratory Problems
[ ] Arthritis	[ ] Emphysema	[ ] Hepatitis	[ ] Rheumatic Fever
[ ] Angina/Chest Pain	[ ] Excessive Bleeding	[ ] Kidney Disease	[ ] Seizures/ Convulsions
[ ] Artificial Joints/Implant	[ ] Fainting	[ ] Liver Disease	[ ] Sinus Problems
[ ] Asthma	[ ] Glaucoma	[ ] Lung Disease	[ ] Stroke
[ ] Autism	[ ] Grind or Clench Teeth	[ ] Psychological Disorders	[ ] Thyroid Disease
[ ] Blood Disease	[ ] Hay Fever	[ ] Jaundice	[ ] Tuberculosis
[ ] Blood Transfusion	[ ] Heart Valve Replacement	[ ] Nervous Disorder	[ ] Tumors
[ ] Cancer	[ ] Heart Attack	[ ] Osteoporosis	[ ] Ulcers
[ ] Chronic Cough	[ ] Heart Surgery	[ ] Are you currently pregnant?	
[ ] Clicking/ Popping Jay	[ ] Heart Disease	[ ] Is it possible you are pregnant?	
[ ] Dizziness	[ ] Heart Palpitations	**Please list any other medications you are taking including	
prescriptions medication, diet drugs, over the counter medications, herbal for holistic remedies, vitamins or minerals:**			

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Are you using any of the following?:

[ ] Antibiotics	[ ] Steroids/Cortisone	[ ] Insulin/Anti-Diabetic Medication
[ ] Blood Thinners	[ ] Aspirin/Motrin/Aleve	[ ] Other:

1) Have you ever used any of the following? Please check all that apply:

[ ] Boniva [ ] Fosamax [ ] Prolia [ ] PhenFen [ ] Zometa [ ] Medication to increase bone density

2) Are you allergic to or have you had an adverse reaction to any of the following?

[ ] Local Anesthesia [ ] Penicillin [ ] Antibodies [ ] Sedatives [ ] Barbiturates [ ] Aspirin [ ] Ibuprofen

[ ] Codeine [ ] Pain Killers [ ] Latex [ ] Rubber [ ] Sulfa [ ] Eggs [ ] Milk [ ] Other_____

3) Have you ever had any complications following a dental treatment? [ ] Y [ ] N

If Yes, Please Explain: _____

4) Do you have any health problems that need further clarification? [ ] Y [ ] N

If Yes, Please Explain: _____

5) Do you smoke tobacco products? [ ] Y [ ] N - Marijuana Products? [ ] Y [ ] N -Vape? [ ] Y [ ] N

If Yes, how much per day?: _____

6) Have you ever had a history of alcohol, chemical dependency or emotional disorders? [ ] Y [ ] N

If Yes, Please Explain: _____

7) Have you or your immediate family members ever had a problem associated with anesthesia?

[ ] Y [ ] N If Yes, Please Explain: _____

8) Have you been admitted to a hospital or needed emergency care during the past two years?

[ ] Y [ ] N If Yes, Please Explain: _____

If you are using oral contraceptives, it is important to understand that antibiotics may interfere with the effectiveness of oral contraceptives. Therefore you will need to use additional forms of birth control IF an antibiotic is prescribed

Desert Valley Oral Surgery and Dr. Donovan Hansen, DDS is not a participation provider under state funded AHCCCS. As an OPT-OUT provider with no authorization to bill for services, the charges for services rendered cannot be billed to these health plans. As a practice, Desert Valley Oral Surgery does not accept reduced fees from the programs nor do we provide billing information. I agree any services rendered in this facility are solely my financial responsibility and I agree to make payments in full at the time of the services, unless prior arrangements have been made. I am fully aware that I have the choice to have services performed under these terms or I can choose to seek treatment with a participating provider.

In the event that any of the office staff or Desert Valley Oral Surgery is injured while performing patient treatment (i.e. needle stick, puncture wound, etc.), Desert Valley Oral Surgery has my full consent to draw a blood sample for the purpose of laboratory testing, this will ensure the safety of all parties who are concerned and involved.

To the best of my knowledge, all of the preceding answers and information provided is true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

I, _____, represents that I am legally authorized to obtain medical services for the patient who is a minor or is under my care.

Signature Patient or Guardian: _____ Date: _____

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Your Pharmacy Information

_____ _____
Patient Name DOB

_____ _____
Patient Height Weight

_____
Name of Pharmacy

_____ _____ _____
Street City Zip

_____
Pharmacy Cross Roads

_____
Pharmacy Phone Number

**** Please fill out entirely to ensure your medications are sent to the correct pharmacy. ****
Thank you

---Office use only below this line ---

Percocet Norco Motrin Peridex Amox Clinda Keflex

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Acknowledgement of Receipt of Notice of Privacy Practices

(You may refuse to sign this Acknowledgement)

I, _____(responsible party name), have received a copy of the office's “Notice of Privacy Practices”.

Print Patient Name: _____

Patient or Guardian/Responsible Party Signature: _____

Date: _____

~For Office Use Only~

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, however acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) _____

Desert Valley
ORAL SURGERY

Financial Policy

Thank you for choosing us as your Oral Surgeon. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment.

All patients must complete our Patient Information Form before seeing the doctor.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, VISA, MASTERCARD, AMERICAN EXPRESS, CHECK, CARE CREDIT & SUNBIT.

REGARDING INSURANCE:

We do accept the assignment of insurance benefits after confirmation of eligibility.

However, we require your estimated portion of the bill to be paid along with your deductible at the time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance unless you bring in all insurance information and fill out the necessary information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

Even though we accept assignment of benefits, we want you to know that if your insurance has not paid your account in full within 60 days, the balance of your account will automatically be your responsibility.

Please be aware, some and perhaps all the services provided may be “non-covered” services excluded from your insurance contract.

As a courtesy, we provide an estimate based on what your insurance company tells us over the phone on the day of service. Estimates are not a guarantee of payment.

Thank you for understanding our Financial policy. Please let us know if you have any questions or concerns.

By signing this form, you have read the financial Policy (above) and understand and agree to this Financial Policy.

Print Patient Name: _____

Patient or Guardian/Responsible Party Signature: _____

Date: _____