TEMPE SMILES
FAMILY DENTAL

Patient Information

Patient Name:_____ Preferred Name:_____

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

Cell Phone:_____ Home Phone:_____

Email:_____ ☐Married ☐Single ☐Child

Gender:_____ Age:_____ Date of Birth:_____ Social Security #:_____

Referred By:_____ Employer:_____

Occupation:_____ Work Phone:_____

Emergency Contact:_____ Phone:_____

Parent / Guardian Information (If under the age of 18)

Parent/Guardian Name:_____ Relationship to child:_____

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

Cell Phone:_____ Home Phone:_____

Gender:_____ Age:_____ Date of Birth:_____ Social Security #:_____

Employer:_____ Occupation:_____

Work Address:_____ Work Phone:_____

Insurance Information

Primary Insured (Subscriber):_____ Relationship to Patient:_____

Date of Birth:_____ Subscriber ID#:_____

Subscriber Employer or Plan Sponsor:_____ Group#:_____

Insurance Company:_____

Additional Insurance

Primary Insured (Subscriber):_____ Relationship to Patient:_____

Date of Birth:_____ Subscriber ID#:_____

Subscriber Employer or Plan Sponsor:_____ Group#:_____

Insurance Company:_____

Authorization and Release

I authorize my insurance company to pay Tempe Smiles all insurance benefits otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges not paid by insurance.** Tempe Smiles may use my health care information and may disclose such information to my insurance company (ies) and their agents for the purpose of obtaining payment for the services and determining insurance benefits payable for related services, as pertaining to the HIPAA guidelines.

Patient/Parent or Guardian Signature **Printed Name** **Date**

Dental History

Reason for today's visit: _____

How often do you brush? _____ How often do you floss? _____

Approx date of last dental visit: _____

Please mark all that apply:

- ☐ TOOTHACHE
- ☐ LOOSE, CHIPPED, CRACKED OR BROKEN FILLINGS
- ☐ LOOSE, CHIPPED, CRACKED OR BROKEN TEETH
- ☐ FOOD CATCHES
- ☐ FLOSSING BREAKS OR HURTS
- ☐ PAIN, CLICKING OR POPPING OF JAW
- ☐ GRINDING OF TEETH
- ☐ CLENCHING OF JAW
- ☐ HEAD ACHES
- ☐ SNORING / SLEEP APNEA
- ☐ SENSITIVITY
  - ☐ COLD
  - ☐ HOT
  - ☐ SWEET
  - ☐ CHEWING
  - ☐ TOUCH
- ☐ SINUS PROBLEM
- ☐ GAGGING
- ☐ DRY MOUTH
- ☐ DARK OR WHITE SPOTS ON TEETH
- ☐ GUMS
  - ☐ BLEEDING
  - ☐ TENDER OR SORE
- ☐ LOOSE TEETH
- ☐ TEETH HAVE SHIFTED
- ☐ BAD BREATH
- ☐ BAD TASTE IN MOUTH
- ☐ SORES OR GROWTHS IN MOUTH
- ☐ OTHER _____

Medical History

Please mark all that apply:

Have you been: ☐ Hospitalized? ☐ Are You Taking Medication? ☐ Do You Have Allergies?

Please describe: _____

_____

YES	NO		YES	NO		YES	NO	
☐	☐	*PRE-MED - AMOX	☐	☐	CANCER_____	☐	☐	MITRAL VALVE PROLAP
☐	☐	*PRE-MED-CLIND	☐	☐	CHEMICAL / DRUG DEPENDENCIES	☐	☐	NERVOUS DISORDERS
☐	☐	*PRE-MED-OTHER_____	☐	☐	CHEMO THERAPY	☐	☐	NURSING
☐	☐	ALLERGY - ASPIRIN	☐	☐	CIRCULATORY PROBLEMS	☐	☐	PACEMAKER
☐	☐	ALLERGY - CODEINE	☐	☐	CORTISONE TREATMENT	☐	☐	PERSISTENT COUGH
☐	☐	ALLERGY - ERYTHRO	☐	☐	DIABETES	☐	☐	PREGNANT
☐	☐	ALLERGY - HAY FEVER	☐	☐	DIZZINESS	☐	☐	RADIATION TREATMENT
☐	☐	ALLERGY - LATEX	☐	☐	EPILEPSY	☐	☐	RESPIRATORY PROBLEMS
☐	☐	ALLERGY - PENICILLIN	☐	☐	FAINTING	☐	☐	RHEUMATIC FEVER
☐	☐	ALLERGY - SULFA	☐	☐	GLAUCOMA	☐	☐	SCARLET FEVER
☐	☐	ALLERGY - OTHER_____	☐	☐	HEAD INJURIES	☐	☐	SHORTNESS OF BREATH
☐	☐	ANEMIA	☐	☐	HEART DISEASE	☐	☐	STROKE
☐	☐	ARTHRITIS	☐	☐	HEART MURMUR	☐	☐	SWELLING FEET / ANKLE
☐	☐	ARTIFICIAL HEART VALVE	☐	☐	HEART PROBLEMS	☐	☐	TAKING BIRTH CONTROL
☐	☐	ARTIFICIAL JOINTS	☐	☐	HEMOPHILIA	☐	☐	THYROID CONDITION
☐	☐	ASTHMA	☐	☐	HEPATITIS	☐	☐	TOBACCO USAGE
☐	☐	BACK PROBLEMS	☐	☐	HIGH BLOOD PRESSURE	☐	☐	TONSILLITIS
☐	☐	BIPHOSPHATE MEDS	☐	☐	HIV	☐	☐	TUBERCULOSIS
		(FosaMax, Acetol, Atelviz, Didronel, Boniva)	☐	☐	JAUNDICE	☐	☐	ULCERS
☐	☐	BLEEDING DISORDERS	☐	☐	KIDNEY DISEASE	☐	☐	VENEREAL DISEASE
☐	☐	BLOOD THINNERS	☐	☐	LIVER DISEASE	☐	☐	OTHER_____
☐	☐	BLOOD DISEASE	☐	☐	MARIJUANA USAGE			
☐	☐	BLOOD TRANSFUSION	☐	☐	MENTAL DISORDERS			

Physicians Name: _____ Phone: _____

Pharmacy Name: _____ Phone: _____

In Office Use

HEAD & NECK EXAM	WNL or : _____
SOFT TISSUE	WNL or : _____
TMJ EXAM	WNL or : _____
OCCLUSION	CLASS I II II
ORTHO	☐ YES ☐ NO

In Office Notes

To the best of my knowledge the above information is accurate and complete. I will not hold the doctor or any members of their staff responsible for any errors or omissions I may have made in the completion of this form.

_____

PATIENT / GUARDIAN SIGNATURE **PRINTED NAME** **DATE**

_____

DR.'S SIGNATURE DATE

TEMPE SMILES
FAMILY DENTAL

Tempe Smiles *is committed to providing you with the best dental care available. We have found that a clear understanding of our office financial guidelines relieve some of the anxiety associated with going to the dentist. We want to be certain that our guidelines are clear and that all of your questions are answered to your satisfaction. For your convenience we honor several different payment plans.*

Payment Options:

When you do not have dental insurance, we ask that you pay for your dental services in full at the end of each appointment. We gladly accept Cash, MasterCard, Visa, Discover and American Express. We also offer Healthy Smiles Dental plan for those without insurance as an added value to you.

Dental Insurance:

As a courtesy we will file your insurance claim for you. We will make a good faith estimate for planned treatment and request that you pay your estimated portion at the time of service. When payment has been received from your insurance carrier, we will settle the outstanding balance of your account with you (there may be a difference between the estimated portion and actual payment). As a service to you, we will complete and file the appropriate claim forms with your insurance carrier(s). We are happy to provide any x-rays or additional information they might require.

If your insurer denies coverage or delays payment beyond 60 days from the claim filing date, the entire amount will become due and payable by you. Although we make every effort to help you obtain your full benefit, there are many variables we cannot anticipate nor control. Please be aware that your insurance benefits are a contract between you, your employer (if applicable) and insurance company.

Financial Services:

We offer CareCredit service that allows you to pay over time with convenient monthly payments.
For more information please inquire with the front office staff.

Cancelling Treatment:

We understand that sometimes a patient may find it necessary to cancel treatment that has not started or is not yet complete. If that treatment was paid in advance then you may be entitled to refund up to the full amount. In cases where treatment is in progress your prepayment will be reduced by the amount of work completed. If you only partially prepaid for this treatment, you could still have a balance due.

Refund Policy:

As part of our fraud and abuse controls our office staff do not have the ability to directly issue a refund. They will submit a refund request to our Accounts Payable department on your behalf. In the event of HSA Accounts or third party payors, like CareCredit, refunds must be processed directly back to the originator and you will receive a credit on your account as opposed to a check in the mail. Our process, including internal controls, takes about two weeks to complete.

We Would Also Like You to Know:

- Our office requires a minimum of 2 business days notice (longer if possible) if you are unable to keep your reserved appointment time.
- YOUR APPOINTMENT IS SPECIFICALLY RESERVED FOR YOU. A fee of $50 per hour of missed appointment time will be charged to the patient for any appointment that is canceled without at least two business days' notice.
- There will be a $25.00 charge for unpaid returned checks.

I authorize payment to be made directly to Tempe Smiles by my insurance company and I accept financial responsibility for all services not covered by my insurance. I authorize release of any medical information requested by my insurance carrier. I agree to pay interest of 1.5% (18% annually) on any balance over 30 days. I hereby agree that in the event of default of any amount due, and if this account is placed with a collection agency or attorney for collection or legal action, to pay an additional charge equal to the cost of collection including any attorney fees and court costs incurred and permitted by laws governing these transactions up to 50% of the family's total balance.

SIGNATURE OF PATIENT / GUARDIAN

Patient/Parent or Guardian Signature	Printed Name	Date

NOTICE OF PRIVACY PRACTICES
Tempe Smiles

Effective Date: January 25, 2026

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

CONTACT INFORMATION

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Privacy Officer.
Telephone: 480.831.8022
7660 S. McClintock Dr #101 Tempe, AZ 85284

OUR LEGAL DUTY

We are required by law to protect the privacy of your protected health information ("medical information"). We are also required to send you this notice about our privacy practices, our legal duties and your rights concerning your medical information.
We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on the date set forth at the top of this page and will remain in effect unless we replace it. We reserve the right at any time to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change in practices.
We may amend the terms of this notice at any time. If we make a material change to our policy practices, we will provide to you, the revised notice. Any revised notice will be effective for all health information we maintain. The effective date of a revised notice will be noted. A copy of the current notice in effect will be available in our facility and on our website. You may request a copy of the current notice at any time. We collect and maintain oral, written and electronic information to administer our business and to provide products, services and information of importance to our patients. We maintain physical, electronic and procedural safeguards in the handling and maintenance of our patients' medical information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction and misuse.

USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION

Treatment: We may disclose your medical information, without your prior approval, to another dentist or healthcare provider working in our facility or otherwise providing you treatment for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, your health information may be disclosed to an oral surgeon to determine whether surgical intervention is needed.
Payment: We provide dental services. Your medical information may be used to seek payment from your insurance plan or from you. For example, your insurance plan may request and receive information on dates that you received services at our facility in order to allow your employer to verify and process your insurance claim.
Health Care Operations: We may use and disclose your medical information, without your prior approval, for health care operations. Health care operations include:

- healthcare quality assessment and improvement activities;
- reviewing and evaluating dental care provider performance, qualifications and competence, health care training programs, provider accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits and legal services, including fraud and abuse detection and prevention; and
- business planning, development, management and general administration including customer service, complaint resolutions and billing, de-identifying medical information, and creating limited data sets for health care operations, public health activities and research.

We may disclose your medical information to another dental or medical provider or to your health plan subject to federal privacy protection laws, as long as the provider or plan has had a relationship with you and the medical information is for that provider's or

health plan's care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You (or your legal personal representative) may give us written authorization to use your medical information or to disclose it to anyone for any purpose. Once you give us authorization to release your medical information, we cannot guarantee that the person to whom the information is provided will not disclose that information. You may take back or "revoke" your written authorization at any time, except if we have already acted based on your authorization. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We will obtain your authorization prior to using your medical information for marketing, fundraising purposes or for commercial use. Once authorize, you may opt out of these communications at any time.

Family, Friends and Others involved in your care or payment for care: We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose on the medical information that is relevant to the person's involvement.

We may use or disclose your name, location and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits, services, payment for those products and services and treatment alternatives.

Reminders: We may use or disclose medical information to send you reminders about your dental care, such as appointment reminders via US Mail, email and telephone. By providing your email address to us, you agree that you may receive reminders and breach notifications via email as a possible alternative to US Mail. It is the policy of our office to leave a message on any voicemail or answering machine that may be attached to a number that you provide (home, cell or work). If you prefer that we NOT leave a message to confirm treatment or your appointments, please check this box.

Plan Sponsors: If your dental insurance coverage is through an employer's sponsored group dental plan, we may share summary health information with the plan sponsor.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law and when authorized by law for the following kinds of public health and public benefit activities;

- for public health, including to report disease and vital statistics, child abuse, adult abuse, neglect or domestic violence;
- to avert a serious an imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

Special protections for SUD records: Substance Use Disorder (SUD) Treatment records have enhanced protections. They cannot be used in legal proceedings without your consent or court order.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Business Associates: We may disclose your medical information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes: We may use your contact information to provide legally required notices of unauthorized acquisition, access or disclosure of your health information.

Additional Restrictions on use and disclosure: Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly Confidential Information" may include confidential information under Federal laws governing reproductive rights, alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

1) HIV/AIDS;
2) Mental Health;
3) Genetic Tests (in accordance with GINA 2009);
4) Alcohol and drug abuse;
5) Sexually transmitted diseases and reproductive health information; and
6) Child or adult abuse or neglect, including sexual assault.

YOUR RIGHTS

1) You have a right to see and get a copy of your health records.
2) You have a right to amend your health information.
3) You have a right to ask to get an Accounting of Disclosures of when and why your health information was shared for certain purposes.
4) You are entitled to receive a Notice of Privacy Practices that tells you how your health information may be used and shared.
5) You may decide if you want to give your Authorization before your health information may be used or shared for certain purposes, such as marketing. It is the policy of our office NOT to sell or disclose your information to any outside firms or business partners. Your information may be used, only within our office, for the purposes of presenting to you certain products or services which our dentist(s) or staff feel may present a benefit for you, your oral health or happiness with your smile. If you would like to opt out of this level of service, you may do so by checking this box.
6) You have the right to receive your information in a confidential manner and restrict certain communication methods.
7) You have a right to restrict who receives your information.
8) You have a right to request amendment to be made to your health records by submitting the request in writing to our privacy officer. Your request does not guarantee the amendment, but does guarantee that it will be reviewed and considered.
9) If you believe your rights are being denied or your health information is not being protected, you can:
    a. File a complaint with your provider or health insurer
    b. File a complaint with the U.S. Government
10) Right to opt out of fundraising activities. If you would like to opt out of any fundraising programs that our office may participate in, such as cancer walks, or other fundraising programs you may do so by checking this box.

COMPLAINTS

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice communication), you may contact our Privacy Officer to register either a verbal or written complaint. You may also submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, DC, 20201. You may contact the Office for Civil Rights' hotline at 1-800-368-1019. We support your right to privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the US Department of Health and Human Services.

Patient/Parent or Guardian Signature Printed Name Date