Affinity Dental

21321 E Ocotillo Rd. #130 Queen Creek, AZ 85142 · 480.882.2300

Adult Dental Registration

Patient Information

Patient Name _____

Date of Birth _____ ☐ Male ☐ Female

Social Security # _____

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other

Address _____

_____

_____

Phone:

Home _____ Work _____

Cell Phone _____

E-mail _____

May we use your email and/or cell phone number to send appointment reminders, confirm your appointments or other information regarding your dental care?

☐ Yes ☐ No

Employer/School _____

Emergency Contact

Name _____

Relationship to Patient _____

Home Phone _____ Cell Phone _____

How did you hear about Affinity Dental?

☐ Referral (their name) _____

☐ Mailing ☐ Social Media (Facebook, Instagram, etc.)

☐ Building Sign ☐ Yelp Online Review

☐ Website ☐ Google Online Review

☐ Insurance Company ☐ DemandForce Online Review

☐ Other _____

Primary Dental Insurance

Subscriber Name _____

Relationship to Patient _____

Date of Birth _____ SS/ID# _____

Address (if different from patient) _____

_____

_____

Subscriber's Employer _____

Insurance Company _____

Group # _____

Secondary Dental Insurance

Subscriber Name _____

Relationship to Patient _____

Date of Birth _____ SS/ID# _____

Address (if different from patient) _____

_____

_____

Subscriber's Employer _____

Insurance Company _____ Group # _____

Cosmetic and Special Services

Are you interested in a FREE consultation or information on any of the following services?

☐ Invisalign Teeth Straightening or Short Term Braces

☐ Lumineers/Veneers

☐ One hour in office instant teeth whitening

☐ Dental Implants

☐ Other _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Affinity Dental
(Name of Insurance Company)
and its associates all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Affinity Dental and its associates may use my health care information and may disclose such information to the above named company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

Signature of Patient or personal representative _____

Print name of Patient or personal representative _____

Relationship to Patient _____

Date _____

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Dental & Medical History Information

Dental History

Patient Name _____ Reason for today's visit _____

Former Dentist _____ City/State _____

Date of last dental visit _____ Date of last dental X-rays _____ How often do you brush? _____ Floss? _____

Please check all dental conditions that apply, past or present:

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Blisters on lips or mouth
- ☐ Burning sensation on tongue
- ☐ Chew on one side of mouth
- ☐ Cigarette/pipe/cigar/smoking
- ☐ Clicking or popping jaw
- ☐ Dry mouth
- ☐ Fingernail biting
- ☐ Food collection between teeth
- ☐ Foreign objects
- ☐ Grinding teeth
- ☐ Gums swollen or tender
- ☐ Jaw pain
- ☐ Jaw tiredness
- ☐ Lip or cheek biting
- ☐ Loose teeth/broken filling(s)
- ☐ Mouth breathing
- ☐ Mouth pain, brushing
- ☐ Orthodontic treatment
- ☐ Pain around ear
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores/growths in mouth

Medical History

Physician's Name _____ City/Phone# _____/(__)__-_____ Date of last visit _____

Please check all that apply:

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Joints
- ☐ Asthma, Use Inhaler: ☐ Yes ☐ No
- ☐ Blood Disease
- ☐ Cancer, Type _____
- ☐ Chemical Dependency
- ☐ Chemotherapy, when _____
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, persistent/bloody
- ☐ Diabetes
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis, type _____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Nervous Problems
- ☐ Pacemakers
- ☐ Psychiatric Care
- ☐ Weight Loss/Gain
- ☐ Radiation Therapy, when _____
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Special Diet
- ☐ Stroke
- ☐ Swollen Feet/Ankles
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor on Head/Neck
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Other _____

Have you ever taken a medication that contains bisphosphonates? This includes brands such as Actonel, Aredia, Boniva, Didronel, Fosamax, Zometa. ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Medications: (List any medications you are currently taking and the correlating diagnosis)

_____

Allergies: (Please check all that apply)

☐ Aspirin ☐ Codeine ☐ Erythromycin ☐ Latex ☐ Local Anesthetic ☐ Metals ☐ Penicillin ☐ Sulfa ☐ Tetracycline ☐ Other _____

I certify to the accuracy of the above statements regarding my medical and dental history.

_____ Signature of patient, parent guardian or representative

_____ Print name of patient, parent guardian or representative

_____ Date

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Financial Policies & General Consent for Treatment

Please read through the following information. After reading, please provide your signature at the bottom indicating that you fully understand these policies. This form must be signed in order to proceed with your scheduled appointment. If you have any questions or concerns, please ask to speak with the Office Manager. Thank you!

- **Insurance:** We are happy to bill both primary and secondary insurances as a ***courtesy*** for our patients. It must be understood that each patient is ultimately responsible for the cost of services rendered. We will do our best to estimate accurate insurance coverage and patient portions due; however, the contractual agreement is between you and your insurance company. If the insurance company does not pay the full amount anticipated, the patient is responsible for the difference. Payment is expected within 30 days of receiving a statement.
- **Patient Payment:** The patient portion due for services rendered is expected **at the time of service** unless *previous* arrangements have been made. We accept cash, checks, money orders, and all major credit cards.
- **Financing:** We have financing options available through Care Credit. If you have an interest in these options, please consult with the Office Manager prior to the date of scheduled treatment.
- **No Shows/Missed Appointments:** We request notice to cancel or reschedule an appointment at least 24 hours in advance. If appropriate notice is not given, a charge of $25 may be assessed to the patient's account. For appointments scheduled for longer than 1 hour, an additional $25 will be charged for each hour missed, i.e. $50 for a 2 hour appointment, $75 for a 3 hour appointment.
- **Refunds for Unfinished Treatment:** If a patient decides to discontinue treatment after it has been started, a full refund will not be given. Individual circumstances may be discussed with the Office Manager and/or Dentist.
- **Credits on an Account:** If an insurance company pays more than anticipated creating a credit for the patient, we are happy to either refund the patient or leave the credit on the account to be applied toward future treatment.
- **Balances.** Balances unpaid after 30 days from the date of billing are subject to a finance charge at a rate of 3% per month (37% per annum).
- **Collections:** On occasion, after repeated attempts to collect a balance due, we may need to turn an account over to a collections agency. Should this occur, it is agreed that the financially responsible party listed below shall pay all finance charges, collection cost, attorneys fees, and any other costs incurred to enforce collection.
- **Returned Checks.** A $35 fee will apply for all checks returned for insufficient funds or closed accounts, and may prevent us from accepting checks as a form of payment for your dental treatment in the future.
- **Right to Discontinue Treatment:** I understand that Affinity Dental has the right to discontinue my care for any appropriate reason, such as excessive missed appointments or lack of compliance. The patient or patient's representative agrees to accept full responsibility for pursuing alternate professional dental care. All records are the property of Affinity Dental. Records/x-rays may be duplicated upon written request and a reasonable fee.
- **General Dentistry Informed Consent for Treatment** includes but is not limited to: Extracting teeth, Dental implants, Dentures or partial dentures, Local anesthesia and medicines, Restoring teeth with fillings or crowns, bridges, veneers, inlays, or onlays, Root canals. I understand that specific informed consents may be made available for any or all of the above procedures. I understand that dental treatment contains no guarantees, warranty, or assurance of success.
- **Risks:** All dental procedures have certain risks; including possible side effects from medicines used. The risks include, but are not limited to: allergic reactions, cuts/abrasions, tenderness/bruising, and tooth sensitivity.

I hereby give permission for diagnosis and /or treatment at Affinity Dental for myself or minor child below. I acknowledge that I have read the above information and have been provided with an opportunity to ask questions about its content. I accept full financial obligation for the services received by the dental professionals at Affinity Dental.

Patient Name: _____

Financially Responsible Person: _____

Signature of Financially Responsible Person: _____ Date: _____

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Insurance and Preventative Services Reminder

We would like you to be aware that, as a courtesy, we will always do our best to verify your insurance for coverage at the time of service. HOWEVER, due to the growing number of insurance companies and policies, there is **no guarantee of benefits** and your insurance can retract verification at any time. It is YOUR responsibility to verify that you are eligible for your dental services. Any claims not paid by your insurance in a timely manner (within 90 days) is your responsibility. **The contract for insurance is between you and your insurance company.**

A common myth regarding dental insurance is that dental cleanings, exams and x-rays are always "free." While many policies cover these services at no out-of-pocket cost to you, many companies are reducing this coverage by either making a portion of the cost patient responsibility or enforcing limitations for how many times they will cover a certain service, such as an exam. We make significant efforts to obtain these details and to notify you when possible; however, **policies can change without notice**. **Ultimately, the contract is between you and your insurance company.** This means that there may be times when there will be a balance due, even after a cleaning, x-rays or an exam.

X-rays are the most effective way for our doctors to diagnose what is occurring in your mouth. X-rays help to see the developing mouth of children, to see structures or masses that may not be visible through examination, and to verify location of active decay or infection. *We will seek to bill your insurance for your x-rays, but we will not determine what x-rays are needed for proper diagnosis solely based on what your insurance will cover.*

We are proud to provide new state-of-the art x-ray imaging with 3D CT technology! These are called conebeam images and are ideal for specific types of oral health issues. Not every patient will need or receive a conebeam image. When provided, **the fee for a conebeam image is $250 and is due at the time of service.**

Please rest assured that the team at Affinity Dental wants you to receive the most from your insurance coverage and the best possible diagnosis and care available!

Thank you,

Affinity Dental

_____ _____

Signing here indicates acknowledgement of the above information Date

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Acknowledgement of Receipt of Notice of Privacy Practices

****You May Refuse to Sign This Acknowledgment****

If the patient is under 18 years of age, a parent or legal guardian must sign.

I, _____, have received a copy of this office's Notice of Privacy Practices.
{Please Print Patients Name}

_____
{Signature of Patient or Parent/Legal Guardian}

_____
{Date}

Pre-medication, billing statements and appointment reminders:
I am authorizing this office to call me and remind me to take my pre-medication before my dental appointment or provide notice of a billing statement or appointment. They may leave a message for me regarding this information at any number that I have supplied to them. They may leave a message on any answering machine, voice mailbox or with whoever answers the telephone. I also authorize this office to remind me of this information on any reminders that the office will mail or email to me.

Our office requests that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital and insurance company. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

Authorization to Release Information to Family Members and/or Friends

Many of our patients allow family members such as their spouse, parents or others such as friends to call and request appointment times, rescheduling of appointment times for the patient, to go over insurance benefits or financial/billing information, and/or the request results of tests and procedures. Under the requirements for H.I.P.P.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have this information released to family members and/or friends you must sign this form. Signing this form will only give consent to release appointment times, rescheduling of patient appointment times, to go over insurance benefits, and/or the results of tests and procedure to the family members and/or friends indicated below. This consent form will not allow our office to release any other information about you. However, you have the right to revoke this consent, in writing prior to expiration of that one year, except where we have already made disclosures in reliance on your prior consent. I authorize this office to speak with the below listed individuals regarding my appointment times, rescheduling of appointment times, to go over insurance benefits or financial/billing information, and/or the results of tests and procedures.

1. **Individual Name_____ Relation to Patient: _____**
2. **Individual Name_____ Relation to Patient: _____**

_____
{Signature of Patient or Parent/Legal Guardian} (DATE)

NOTICE OF PRIVACY PRACTICES

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.

Affinity Dental is committed to protecting your privacy, and we have adopted privacy practices to protect the information we gather from you. We understand that health/dental information about you and your health is personal. We are committed to protecting health/dental information about you. The Notice of Privacy Practices ("Notice") describes the privacy practices of Affinity Dental and will tell you about the ways in which we may use and disclose health/dental information about you and how you can get access to this information. We also describe your rights and certain obligations we have regarding the use and disclosure of health/dental information with respect to your "Protected Health Information" (as defined by the Health Insurance Portability and Accountability Act of 1996 and its regulations, as amended from time to time).

We typically use or share your health information in the following ways:

- Treat you. We can use your health information and share it with other professionals who are treating you. An example of this would be a doctor treating you for an injury asks another doctor about your overall health condition.
- Bill for your services. We can use and share your health information to bill and get payment from health plans or other entities. An example of this would be sending a bill for your visit to your insurance company for payment.
- Run our office. We can use and share your health information to run our practice, improve your care, and contact you when necessary. An example would be an internal quality assessment review. This may include quality assessment, staff training, accreditation, licensing activities, and business planning and development.

How else can we use or share your health information. We are allowed or required to share your information in other ways – usually to contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- Help with public health and safety issues. We can share health information for certain situations, such as preventing disease, reporting suspected abuse, neglect, or domestic violence, preventing/reducing a serious threat to anyone's health or safety.
- Comply with law. We will share information about you if state or federal law requires it, including with the U.S. Department of Health and Human Services if it wants to see that we are complying with federal privacy law.
- Do Research. We can use and share information for health research.
- Family and Friends: We may disclose your health information to a family member or friend who is involved in your medical care or to someone who helps pay for your care. We may also use or disclose your health information to notify (or assist in notifying) a family member, legally authorized representative, or other person responsible for your care of your location, general condition, or death. If you are a minor, we may release your health information to your parents or legal guardians when we are permitted or required to do so under federal and applicable state law.
- Organ and tissue donation requests. We can share information about you to organ procurement organizations.
- Medical examiner or funeral director. We can share information with a coroner, medical examiner, or funeral director when an individual dies.
- Worker compensation, law enforcement requests, and other governmental requests. We can share health information for worker compensation claims, law enforcement purposes, with health oversight agencies for activities allowed by law, and other specialized government functions (e.g., military and national security).
- Lawsuits and legal actions. We can share health information in response to court or administrative order, or in response to a subpoena.
- Reproductive health care information. Federal rules may limit when we may use or disclose protected health information related to lawful reproductive health care for certain non-health-care purposes (such as certain investigations, law enforcement requests, oversight activities, or legal proceedings). When required, we may need to obtain a signed attestation from the requester before making certain disclosures.

When it comes to your health information, you have certain rights under federal and applicable state law:

- Get an electronic or paper copy of your health/dental information. You can ask to see or get a copy of your health information that we maintain in a designated record set. We will provide a copy or a summary, as you request, within 30 days (or we will provide you a written explanation if we need more time as allowed by law). If we maintain your information electronically, you may request an electronic copy. You may also request that we send a copy to a person or organization you choose (your request must be in writing, signed, and clearly identify where to send it). We may charge a reasonable, cost-based fee as allowed by law.
- Ask us to correct your health/dental record. You can ask us to correct health information about you that you think is incomplete or incorrect. We may say "no" to your request, but we will tell you why in writing within 60 days.
- Confidential communications. You can ask us to contact you in a specific way (for instance home or office phone) or to send mail to a different address for items such as appointment reminders. We will say yes to all reasonable requests.
- Limits on what we use and share. You can ask us NOT to share certain health information for treatment, payment, or operations. We are not required to agree to your request, and if it affects your care, we may say no. If you pay for a service or item in full out-of-pocket, you can ask us not to share information about that service or item with your health plan for payment or our operations. We will agree unless a law requires us to share that information.
- Accounting of disclosures. You can ask for a list (accounting) of the times we have shared your health information for the prior six years. We will include all disclosures, except those about treatment, payment, and operations. We will provide one accounting for free, but may charge a reasonable, cost-based fee if you ask for another within 12 months.

- Substance Use Disorder (SUD) Records (42 CFR Part 2) (if applicable). If we receive or maintain records that are subject to 42 CFR Part 2, those records may have additional federal protections and limitations on use and disclosure. We will follow applicable Part 2 requirements when they apply, including any requirements related to patient consent and restrictions on redisclosure.
- Fundraising**.** We do not use your information for fundraising communications.
- Privacy Notice. You can ask and receive a paper copy of this notice at any time.
- Complaint. You can file a complaint if you feel we have violated your rights, with the office at the address below, or you with the Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, SW, Room 509F HHH Bldg., Washington, D.C. 20201, calling 1-877-696-6775, or by visiting: www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Uses and disclosures that require your written authorization: We will not use or disclose your protected health information without your written authorization for the following purposes (except as otherwise permitted by law):

- Marketing.
- Sale of protected health information.
- Most uses and disclosures of psychotherapy notes (if applicable).

You may revoke your authorization in writing at any time unless we have already acted based on it.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

State Law

We will not use or share your information if state law prohibits it. Some states have laws that are stricter than the federal privacy regulations, such as laws protecting HIV/AIDS information or mental health information. If a state law applies to us and is stricter or places limits on the ways we can use or share your health information, we will follow the state law. If you would like to know more about any applicable state laws, please ask our Privacy Officer. Some types of information (for example, certain mental health, HIV/AIDS, genetic, or substance use disorder information) may have additional protections under applicable law.

We are required by law to maintain the privacy and security of your protected health information. We will notify you following applicable legal requirements if a breach occurs that may have compromised the privacy or security of your information. This notice is effective as of January 1, 2026. We reserve the right to change this Notice, and the changes will apply to all protected health information we maintain. We will make the updated Notice available upon request, in our office, and on our website (if applicable)

If you have any questions or want more information about this notice or how to exercise your health information rights, you may contact our Privacy Officer, Affinity Dental, by mail at: 21321 E Ocotillo Road, Ste. 130, Queen Creek, AZ, 85142 or telephone at 480-882-2300. You have the right to exercise any of the actions in the above document, and the Privacy Officer will guide you through the process.

☐ I request that information not be discussed with family or friends except as permitted by law (for example, in emergencies).
☐ I authorize information about treatment or appointments to be discussed with the following person(s):

_____

_____

I have read and understand the above information.

_____ _____
First Name Last Name Date of Birth

_____ _____
Patient Signature (or Authorized Representative) Date

For office use only

The following patient/authorized representative _____

☐ Refused to sign the Notice of Privacy Practices because _____

☐ Was unable to sign the Notice of Privacy Practices because _____