SHELDON SULLIVAN, D.D.S.

ARTISTRY in DENTISTRY

We are a health centered dental practice. Thus, we are concerned with your total well-being. Please fill out the health questionnaire completely, even if some of the questions may not seem relevant to your dental health. Thank you!

Name(Last) (First) (Middle) Date of Birth / / Sex M F Marital Status S M D W Social Security Number

Home Address (Street) (City) (State) (Zip Code) Home Phone Number

Cell Number Work Number Email Address

What is the best way to reach you?_____

If full time Student:

Name of Employer Occupation Name of School

Business Address (Street) (City) (State) (Zip Code)

Height Weight Spouse's Name Spouse's Phone Number

In Case of Emergency call: Phone Number Other Phone Number

General Health (please check): EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐

Name of Physician

Physician's address phone number date of last physical

Who may we thank for referring you to our office?_____

When would you like to start treatment?_____

What, if anything, has happened in previous experiences at the dentist that was reason not to return?_____

Do you have missing teeth?_____ If yes, have you had them replaced?_____ If you have had missing teeth replaced, are you happy with the results?_____ If not, would you like to learn about your options to replace them?_____

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

What type of brush do you use? SOFT ____MED____HARD____

Do you lose or break fillings?_____

Do you chew on only one side of your mouth?_____ If yes, explain_____

Do you usually have many cavities?_____

Do your jaws ever feel tired?_____

Do you get food caught between your teeth?_____

COSMETIC/ESTHETIC EVALUATION

Are you delighted with your smile?_____ Please rate your smile from 1 to 10 (1= I hate my smile, 10= awesome) _____

Would you like to have whiter teeth?_____

If you had a magic wand what, if anything, would you change about your smile?_____

Do you have any special occasions coming up?_____

Please indicate which of the following would be of interest to you:

☐ Lighten all front teeth showing	☐ Rebuild fracture(s)	☐ Straighten rotation	☐ Eliminate dark or stained fillings
☐ Lighten single tooth	☐ Lengthen	☐ Straighten angulation	☐ Reduce gum showing in smile
☐ Close spaces between teeth	☐ Shorten	☐ Eliminate crowding	☐ Repair uneven edges

Please add anything you feel is important for us to know:_____

Patient Signature Date

MEDICAL HISTORY

Patient Name_____ Nickname_____ Age_____

Name of Physician_____ Physician Phone_____

Most recent physical examination_____ Purpose_____

What is your estimate of your general health? Poor _____ Fair _____ Good _____

HAVE YOU EVER HAD THE FOLLOWING:	YES	NO
1. hospitalization for illness or injury……	☐	☐
2. allergic reaction to		
aspirin, ibuprofen, acetomenophen…….	☐	☐
penicillin……	☐	☐
erythromycin……	☐	☐
tetracycline……...	☐	☐
codeine……	☐	☐
local anesthetic……	☐	☐
fluoride……..	☐	☐
metals (gold, stainless steel)……	☐	☐
latex……	☐	☐
any other medications_____		
3. heart problems……..	☐	☐
4. heart murmur……	☐	☐
5. rheumatic fever……..	☐	☐
6. scarlet fever……	☐	☐
7. high blood pressure……..	☐	☐
8. low blood pressure……	☐	☐
9. a stroke……	☐	☐
10. artificial prosthesis (ie heart valve or joints)……..	☐	☐
11. anemia or other blood disorder……..	☐	☐
12. prolonged bleeding due to a slight cut……	☐	☐
13. emphysema……	☐	☐
14. tuberculosis ……	☐	☐
15. asthma……..	☐	☐
16. sinus problems……	☐	☐
17. kidney disease……	☐	☐
18. liver disease……	☐	☐
19. jaundice……	☐	☐
20. thyroid or parathyroid disease……..	☐	☐
21. hormone deficiency……	☐	☐
22. high cholesterol……	☐	☐
23. diabetes……	☐	☐

	YES	NO
24. stomach or duodenal ulcer……..	☐	☐
25. digestive disorders……	☐	☐
26. arthritis……	☐	☐
27. glaucoma……	☐	☐
28. contact lenses……	☐	☐
29. head or neck injuries……	☐	☐
30. epilepsy, convulsions (seizures)…….	☐	☐
31. viral infections and cold sores…….	☐	☐
32. any lumps or swelling in the mouth...	☐	☐
33. hives, skin rash, hay fever……..	☐	☐
34. venereal disease……..	☐	☐
35.hepatitis (type_____)……...	☐	☐
36. HIV / AIDS……	☐	☐
37. tumor, abnormal growth……..	☐	☐
38. radiation therapy……...	☐	☐
39. chemotherapy……	☐	☐
40. emotional problems……...	☐	☐
41. psychiatric treatment……	☐	☐
42. antidepressant medication……..	☐	☐
43. alcohol / drug dependency……..	☐	☐
ARE YOU:		
44. presently being treated for any illness	☐	☐
45. aware of a change in your general health	☐	☐
46. often exhausted or fatigued……	☐	☐
47. subject to frequent headaches……	☐	☐
48. a heavy smoker (1+ pack a day)……	☐	☐
49. Do you use smokeless tobacco?…...	☐	☐
50. considered a touchy person……	☐	☐
51. often unhappy or depressed……..	☐	☐
52. easily upset or irritated……	☐	☐
53. FEMALE – taking birth control pills…	☐	☐
54. FEMALE – pregnant……	☐	☐
55. MALE – prostate disorders……	☐	☐

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment_____

List any medications, herbal supplements, and or vitamins taken within the last two years_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patients Signature_____ Date_____

Doctor's Remarks:_____

_____ Doctor's Signature_____

OVER

DENTAL HISTORY

Previous dentist _____ How long _____

Most recent dental exam _____ Most recent dental x-ray _____

Most recent dental treatment _____

How often do you have your teeth cleaned? 3 mo._____ 4 mo._____ 6 mo._____ 1 year or longer _____

WHAT IS THE REASON FOR YOU VISIT? _____

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	YES	NO
1. unhappy with the appearance of your teeth	☐	☐
2. unfavorable dental experiences	☐	☐
3. dental fears	☐	☐
4. problems with effectiveness or bad reactions to dental anesthetic	☐	☐
5. orthodontic treatment (braces) when	☐	☐
6. periodontal (gum)	☐	☐
7. bleeding gums	☐	☐
8. avoid brushing any part of your mouth	☐	☐
9. part of your mouth is sensitive to temperature	☐	☐
10. sore teeth	☐	☐
11. a burning sensation in your mouth	☐	☐
12. difficulty swallowing	☐	☐
13. an unpleasant taste or odor in your mouth	☐	☐
14. dry mouth, throat, and or eyes	☐	☐
15. jaw problems (temporomandibular joint)	☐	☐
16. difficulty opening your mouth widely	☐	☐
17. stiff neck muscles	☐	☐
18. awaken with an awareness of your teeth or jaws	☐	☐
19. tension headaches	☐	☐
20. clench or grind your teeth	☐	☐
21. jaw clicking or popping	☐	☐
22. lost any teeth	☐	☐
23. do you sweat or tremble a lot during examination	☐	☐
24. do strange people or places make you afraid	☐	☐

SUPPLEMENTAL DENTURE HISTORY:

If you are wearing a partial or complete artificial denture, please complete the following:

YES	NO	(Please check Yes or No)
☐	☐	Has your present denture been relined? When _____
☐	☐	Is your present denture a problem? Describe _____
☐	☐	Satisfied with the appearance? _____
☐	☐	Satisfied with the comfort? _____
☐	☐	Satisfied with the chewing ability? _____

When did you receive your first partial or complete denture? _____

How long have you worn your present denture? _____

Patient's Signature _____ Date _____

Doctor's Remarks: _____

_____ Doctor's Signature _____

Our goal is to provide you with excellent dental care. As a patient, it is easy to forget that a health care office is also a business. We want our patients to understand that an important part of any business is collecting payment for services rendered. In the interest of providing excellent care and doing good business we have established the following financial policy:

INSURANCE

If you have dental insurance, remember that your coverage is a contract between you and your insurance company. As a courtesy we will submit your dental claim forms and work to maximize your insurance benefits.
Please note: We are a private, fee for service dental office. While we are able to accept any open insurance plan, we are **out of network** for all insurance companies other than Delta Dental. We are contracted with Delta Dental as a Premier Provider. We are not a preferred provider for any other insurance company, nor are we part of a DHMO. If we were, we would be obligated to them and not to you, the patient.

WE REQUIRE THAT YOU PAY AT THE TIME OF YOUR VISIT

Whether you have dental insurance or not, we ask that you pay for services when they are rendered. In the event that you have dental insurance we ask that you pay your ***estimated*** portion. Treatment and financial estimates are subject to change if dental procedures are altered in any way.
Please understand that due to the differences in insurance company's allowable fee schedules we are only able to ***estimate*** your percentage due on the day of your appointment. When your insurance company pays, we will settle any differences between the actual payment and our estimate with you. The difference will be due upon receipt of our statement. Any overpayments by you will be reimbursed to you when dental treatment has been completed.
The **financial obligation for dental treatment is between you and our office.** The insurance company is **responsible to you, and not our office.**

FORMS OF PAYMENT AND BALANCES DUE

In order to facilitate access to the very best health care possible, you may choose from any of the following options: Cash, Check, MasterCard, Visa, Discover, American Express, CareCredit and Lending Club Financing. Balances over 30 days will incur a finance charge of $10 per month.

The time reserved in our office for your appointment is your responsibility. If you are unable to keep your reserved appointment, please provide us with at least 2 days notice during our office hours of Monday through Thursday. In the unfortunate event that you are unable to keep your scheduled time and have not given adequate notice, a late cancellation fee of a minimum $50 (amount will be based on the amount of time reserved) will be assessed to your account.

I have read, understand, and accept the terms of the financial policies outlined above for dental services. I agree to honor these policies, to pay for services rendered at the time of service or if I have insurance, the estimated patient portion. I agree that I am ultimately responsible for all charges incurred as a result of treatment by Dr. Sullivan. I agree to pay a $10 monthly billing fee if my account is 30 days past due. I agree to give adequate notice when possible when I am unable to keep my appointment.

***Acknowledgment**:*
I, (print) _____ have reviewed a copy of this office's Notice of Privacy Practices and agree to the financial terms set above.

Signature_____ Date _____

Relationship to patient (if other than patient) _____

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you (the patient). The Notice contains a Patient Rights section describing your rights under the law (this may be requested at the front desk). You have the right to review our full Notice before signing Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict protected health information about you that is used or disclosed for treatment, payment or healthcare operations.

By signing this form, you consent that you have had the opportunity to read our Notice of Privacy Practices and consent to our use and disclosure of protected health information about your treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The practice reserves the right to change the Notice of Privacy Policy.
- The patient has the right to restrict the use of their information.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The practice may condition treatment upon execution of this consent. No insurance can be billed on the patient's behalf without this signed HIPAA consent form therefore payment in full is required at the time services are rendered.

Information Sharing: Please list any individuals we can share your personal information with other than healthcare providers.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____

This HIPAA Consent/Sharing was signed by:

_____

Relationship to patient (if other than patient)

SHELDON SULLIVAN DDS

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOU TYOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. WE are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/2003 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:
Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.
Required by Law: We may use or disclose your health information when we are required to do so by law.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 of protected health information of inmate or patient under certain circumstances.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information

listed at the end of this Notice. We will chare you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.50 per page, $50.00 per x-ray duplicated, $20.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operation and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. WE are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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.

Electronic Notice: If you receive this Notice on our Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 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 info listed at the end of this Notice. You also may submit a written complaint to the U.S. Dept. of Health and Human Services. We will provide you with their address 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. Dept. of Health and Human Services.

Contact Officer: Jennifer Richey
Telephone: 480-507-1993 Fax: 480-507-3876
Address: 3303 E. Baseline Rd. #105
Gilbert, AZ 85234