PATIENT INFORMATION

(PLEASE FILL OUT IN INK, ALL INFORMATION GIVEN IS CONFIDENTIAL)

TODAY'S DATE:_____

PATIENTS NAME:_____

IF PATIENT IS A CHILD, PARENT'S NAME:_____

HOME ADDRESS:_____
(IF P.O. BOX, NEED STREET ADDRESS ALSO)

D.O.B.: _____/_____/_____ **AGE:**_____**MALE:**_____**FEMALE:**_____

HOME PHONE:_____**PAGER/OTHER:**_____

WORK PHONE:_____**CELL/MESSAGE:**_____

E-MAIL ADDRESS_____

WOULD YOU LIKE TO RECEIVE E-MAIL CONFIRMATION FOR APPOINTMENTS: YES NO

SSN:_____/_____/_____ **OCCUPATION:**_____

SINGLE_____**DIVORCED**_____**WIDOWED**_____**SEPARATED**_____

MARRIED_____ **SPOUSE NAME:**_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

LAST DENTAL VISIT DATE:_____ **LAST X-RAYS TAKEN:**_____

DENTAL INSURANCE

PLEASE REMEMBER TO BRING INSURANCE CARD

INSURANCE CO. NAME:_____

INSURANCE CO. ADDRESS:_____

INSURANCE CO. PHONE# :_____

GROUP #:_____**ID#**_____

PRIMARY INSURED'S NAME:_____

INSURED'S D.O.B.: _____/____/_____ **INSURED'S SSN:** _____/_____/_____

INSURED'S EMPLOYER:_____

EMPLOYER'S ADDRESS:_____

MEDICINE WHEEL DENTAL
HEALTH HISTORY
ALL INFORMATION GIVEN IS CONFIDENTIAL

NAME:_____ **DATE:**_____**AGE:**_____

DATE OF BIRTH:_____**M**_____ **F**_____

SPOUSE/PARENT:_____

DO YOU HAVE A BIO-COMPATIBILITY TEST? YES_____ **NO**_____
IF YES, YEAR AND FROM WHOM?_____

HAVE YOU BEEN EXAMINED BY A PHYSICIAN WITHIN THE LAST (CIRCLE ONE) 1-3 MONTHS 6 MONTHS-YEAR NEVER
PHYSICIAN'S NAME_____
WHAT MEDICATIONS HAVE YOU TAKEN IN THE LAST YEAR (INCLUDING BIRTH CONTROL PILLS AND VITAMINS)_____
_____

	PAST	CURRENT	NO
ALLERGIES TO MEDICATIONS	⬭	⬭	⬭
IF CURRENT PLEASE STATE			
ALLERGIES	⬭	⬭	⬭
HIVES/SKIN RASHES	⬭	⬭	⬭
HEART OR CIRCULATION PROBLEMS	⬭	⬭	⬭
HIGH/LOW BLOOD PRESSURE (CIRCLE)	⬭	⬭	⬭
HEART MURMUR	⬭	⬭	⬭
MITRAL VALVE PROLAPSE	⬭	⬭	⬭
HEART ATTACK	⬭	⬭	⬭
STROKE	⬭	⬭	⬭
FAINTING SPELLS	⬭	⬭	⬭
BLOOD TRANSFUSION	⬭	⬭	⬭
PROLONGED BLEEDING FROM CUTS/EXTRACTIONS	⬭	⬭	⬭
ANEMIA, BLOOD DISORDERS	⬭	⬭	⬭
HIV, ARC, AIDS (CIRCLE)	⬭	⬭	⬭
SWOLLEN ANKLES	⬭	⬭	⬭
HEART PALPITATIONS	⬭	⬭	⬭
BRUISE EASILY	⬭	⬭	⬭
RESPIRATORY/BREATHING PROBLEMS			
ASTHMA/HAY FEVER	⬭	⬭	⬭
SINUS PROBLEMS	⬭	⬭	⬭
LUNG DISEASE	⬭	⬭	⬭
TUBERCULOSIS (T.B.)	⬭	⬭	⬭
CHEST PAINS, OR SHORTNESS OF BREATH W/EXTRACTIONS	⬭	⬭	⬭
PNEUMONIA	⬭	⬭	⬭
CHRONIC COUGH	⬭	⬭	⬭
EMPHYSEMA	⬭	⬭	⬭
GASTRO INTESTINAL PROBLEMS			
UNEXPLAINED WEIGHT LOSS	⬭	⬭	⬭
CONSTIPATION/ DIARRHEA	⬭	⬭	⬭
JAUNDICE/LIVER PROBLEMS	⬭	⬭	⬭
CHRONIC ABDOMINAL PAIN	⬭	⬭	⬭
COLITIS/ULCER/NERVOUS STOMACH	⬭	⬭	⬭
DIFFICULTY SWALLOWING	⬭	⬭	⬭
LOSS OF APPETITE	⬭	⬭	⬭
HEMORRHOIDS	⬭	⬭	⬭

	PAST	CURRENT	NO
URINARY OR GENITAL PROBLEMS	⬭	⬭	⬭
VENEREAL/SEXUALLY TRANSMITTED DISEASE	⬭	⬭	⬭
IF CURRENT, WHAT TYPE			
KIDNEY OR BLADDER PROBLEMS	⬭	⬭	⬭
EXCESSIVE URINATION,PAIN,POOR CONTROL	⬭	⬭	⬭
DECREASED FORCE OF URINATION	⬭	⬭	⬭
BLOOD IN URINE	⬭	⬭	⬭
PROSTATE PROBLEMS	⬭	⬭	⬭
WOMEN: ARE YOU PREGNANT?	YES	NO	
NUMBER OF PREGNANCIES			
NUMBER OF LIVE BIRTHS			
DIFFICULTIES WITH CHILDBIRTH?	⬭	⬭	⬭
PMS (MODERATE OR SEVERE?)	⬭	⬭	⬭
NEUROLOGICAL PROBLEMS			
EPILEPSY/CONVULSIONS OR SEIZURES	⬭	⬭	⬭
BLACKOUTS OR FAINTING SPELLS	⬭	⬭	⬭
NUMBNESS/TIGHTNESS SENSATIONS	⬭	⬭	⬭
TREMORS	⬭	⬭	⬭
EYE PROBLEMS			
CONTACT LENSES/GLASSES	⬭	⬭	⬭
EYE PAIN	⬭	⬭	⬭
BLURRED OR DOUBLE VISION	⬭	⬭	⬭
EAR PROBLEMS			
DIFFICULTY HEARING	⬭	⬭	⬭
PAIN IN/AROUND EARS	⬭	⬭	⬭
RINGING OR HIGH PITCHED SOUNDS	⬭	⬭	⬭
EAR INFECTIONS	⬭	⬭	⬭
DIZZINESS OR LOSS OF BALANCE	⬭	⬭	⬭
THROAT PROBLEMS			
SWALLOWING PROBLEMS OR CHRONIC HOARSENESS	⬭	⬭	⬭
FREQUENT SORE THROAT	⬭	⬭	⬭
ENDOCRINE PROBLEMS			
EXCESSIVE THIRST	⬭	⬭	⬭
DIABETES	⬭	⬭	⬭
HYPOGLYCEMIA/LOW BLOOD SUGAR	⬭	⬭	⬭

	PAST	CURRENT	NO
MOUTH AND TEETH PROBLEMS			
SENSITIVITY TO COLD,HEAT,SWEETS,PRESSURE	⬭	⬭	⬭
HERPES, COLD OR CANKER SORES	⬭	⬭	⬭
BLEEDING GUMS WHILE BRUSHING/FLOSSING	⬭	⬭	⬭
FOOD PACKS BETWEEN TEETH	⬭	⬭	⬭
FLOSS TEARS OR HARD TO USE	⬭	⬭	⬭
FLOSS DAILY	⬭	⬭	⬭
TENDER, SWOLLEN GUMS	⬭	⬭	⬭
PREVIOUS GUM TREATMENT	⬭	⬭	⬭
BURNING TONGUE	⬭	⬭	⬭
METALLIC TASTE IN MOUTH	⬭	⬭	⬭
BAD BREATH/UNPLEASANT TASTE IN MOUTH	⬭	⬭	⬭
SWELLING, LUMPS IN MOUTH	⬭	⬭	⬭
TOOTHACHE	⬭	⬭	⬭
SORE/DRY MOUTH	⬭	⬭	⬭
PROBLEMS WITH DENTAL CARE	⬭	⬭	⬭
JAW PROBLEMS			
POPPING OR CLICKING WHEN CHEWING	⬭	⬭	⬭
HARD TO CHEW FOOD	⬭	⬭	⬭
JAW STIFF OR HARD TO OPEN (CIRCLE)	⬭	⬭	⬭
JAW LOCKS OPEN/CLOSED	⬭	⬭	⬭
WAKE UP WITH TIGHT JAW	⬭	⬭	⬭
DO YOU CLENCH/GRIND YOUR TEETH (CIRCLE)	⬭	⬭	⬭
DO YOU TEND TO KEEP YOUR TEETH TOUCHING	⬭	⬭	⬭
ANY INJURIES TO YOUR FACE OR JAW	⬭	⬭	⬭
HAVE YOU EVER HAD ORTHODONTICS	⬭	⬭	⬭
HEADACHES OR MIGRAINES (CIRCLE)	⬭	⬭	⬭
HOW OFTEN?			
MUSCULOSKELETAL: ANY BODY ACHES			
CHRONIC NECK OR UPPER SHOULDER TENSION	⬭	⬭	⬭
BACKACHES	⬭	⬭	⬭
ANY RESTRICTION OF RANGE OF MOTION	⬭	⬭	⬭
TIGHTNESS OR STIFFNESS	⬭	⬭	⬭
ARTHRITIS/PAINFUL OR SWOLLEN JOINTS	⬭	⬭	⬭
HIP OR SHOULDER PROBLEMS	⬭	⬭	⬭
OTHER PROBLEMS			
HISTORY OF ANY PROLONGED ILLNESS	⬭	⬭	⬭
SWOLLEN OR TENDER AREAS	⬭	⬭	⬭
HEPATITIS (INFECTIOUS/SERUM)	⬭	⬭	⬭
IF CURRENT WHAT TYPE?			
MONONUCLEOSIS	⬭	⬭	⬭
LOW ENERGY	⬭	⬭	⬭
PROBLEM WITH SKIN, HAIR OR NAILS	⬭	⬭	⬭
EMOTIONAL PROBLEMS	⬭	⬭	⬭
COLD OR NUMB HANDS OR FEET	⬭	⬭	⬭
MOODINESS	⬭	⬭	⬭
CHRONIC FATIGUE	⬭	⬭	⬭
PROCRASTINATION	⬭	⬭	⬭
CANCER/MALIGNANCIES	⬭	⬭	⬭
ALCOHOLISM	⬭	⬭	⬭

	PAST	CURRENT	NO
RECOVERY GROUP	⬭	⬭	⬭
FEARS OR PHOBIAS	⬭	⬭	⬭
DIFFICULTY SLEEPING	⬭	⬭	⬭
MEMORY LOSS	⬭	⬭	⬭
MEASLES	⬭	⬭	⬭
GERMAN MEASLES	⬭	⬭	⬭
SCARLET FEVER	⬭	⬭	⬭
POLIO	⬭	⬭	⬭
CHICKEN POX	⬭	⬭	⬭
REACTIONS TO INOCULATIONS	⬭	⬭	⬭
DO YOU TAKE ASPIRIN,TYLENOL OR ADVIL	⬭	⬭	⬭
HOW OFTEN?			
MALARIA	⬭	⬭	⬭
TYPHOID FEVER	⬭	⬭	⬭
MUMPS	⬭	⬭	⬭
RECREATIONAL DRUG USE	⬭	⬭	⬭
ALCOHOL	⬭	⬭	⬭
HOW OFTEN?			
SMOKING	⬭	⬭	⬭
HOW MANY PER DAY?			
COFFEE OR TEA (CIRCLE)	⬭	⬭	⬭
HOW MANY CUPS PER DAY?			
HISTORY OF STEROID USE	⬭	⬭	⬭
DO YOU AVOID FATS/OILS/SUGAR (CIRCLE)	⬭	⬭	⬭
IS THERE ANYTHING YOU'VE LEFT OUT?			
ANY SURGERIES OR OPERATIONS?			
ANY PINS, PLATES, ARTIFICIAL JOINTS/ARTIFICIAL VALVES OR REPLACEMENT PARTS?			
PLEASE LIST PHYSICIANS AND WHAT THEY ARE TREATING YOU FOR?			
PHYSICIANS NAME — CONDITION OR ILLNESS			
DO YOU NEED TO BE PREMEDICATED BEFORE DENTAL TREATMENT: YES NO			
IF YES, PLEASE INDICATE			

I UNDERSTAND THAT THE INFORMATION THAT I HAVE GIVEN TODAY IS CORRECT TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND THAT THE INFORMATION WILL BE HELD IN THE STRICTEST OF CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THE OFFICE OF ANY CHANGES IN MY MEDICAL STATUS.

PATIENT'S SIGNATURE DATE

Medicine Wheel Dental Office Policy Form

Welcome to Medicine Wheel Dental & Wellness Center (MWD). We are pleased that you have decided to choose our practice to assist in achieving optimal oral health. It is our goal to provide you with the very best in dental care, customer service, and an excellent overall experience.

Office Hours: Regular office hours are Monday-Thursday 8:30 am – 4:00 pm and Friday from 9:00 am to 3:00 pm. The office is closed on all major holidays as well as when the doctor(s) and team are attending continuing education programs to maximize our knowledge of the latest developments to better serve our patients.

Fees and Payment Policy: In an effort to keep your dental costs down while maintaining the highest level of professional care as well as the extra time we spend with our patients, payment is due when services are rendered. Payment may be paid as follows: *Cash, Personal Check, Money Order, Visa, MasterCard, Discover, American Express, and Care Credit*. All treatments involving our dental laboratory will require a minimum down payment of ½ the procedure cost. The remaining portion of the procedure cost will be due upon completion of that procedure.

Insurance: MWD is a fee for service office. We work for you (our patients) directly and not the insurance companies. This allows us to spend more quality time with our patients and provide a more comprehensive service. If you have dental insurance, we do collect payment from our patients directly. We then submit your dental insurance claims as well as all information requested by your insurance company to process the claim on your behalf. We request that any and all benefits paid be sent directly to you.

Acknowledgement of Policies: We ensure that our time spent together is productive and efficient. In an effort to do so, we outlined our office policies and request you acknowledge them to ensure our mutual understanding. Should you have questions regarding any of our policies, please ask a member of our team who will ensure your questions are discussed and answered fully.

Please initial each of the following:

1. I understand that I am responsible for obtaining my records from any current or previous dental office and that if these records are not on file at the time of my examination, MWD may require current records (x-rays, perio charting, etc.), and that additional costs may apply for these records____ **(initial)**

2. In the event of a missed appointment, I understand that I may be financially responsible for the time I have reserved, MWD requires a minimum of 48 hours notice. Fees for a missed appointment are - $45 per hour for appointments with the hygienists and $95 per hour for appointments with the dentist ____ **(initial)**

3. I understand I am responsible for payment in full at the time services are rendered (even if I have dental insurance coverage) and that MWD does not guarantee insurance benefits or the amount of insurance benefits payable to me____ **(initial)**

4. I understand that any account balance left outstanding for more than 90 days without a financial arrangement approved and documented by MWD will bear interest at 1.5% per month. I further agree to pay all finance charges, collection costs (30%), attorney fees, and any other cost that may have incurred to enforce collection of any amount outstanding____ **(initial)**

Patient Signature_____ Date_____

NOTICE OF PRIVACY PRACTICES

Medicine Wheel Dental
Dr. Steven A. Swidler DDS
Dr. Kenneth C. Glass DDS
PO Box 85490
Tucson, AZ 85754
(520) 743-7101 (office) - (520) 743-0450 (fax)
medicinewheeldental@gmail.com
Contact Person – Ari S. (Office Manager)

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office with other practitioners whom you are or will be a patient of we usually will not ask you for special written permission. We will ask for special written permission in the event that your records are requested by any entity other then you.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;

- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written

request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have read and understand the information provided on this notices, and that I have been given the option to receive a copy of Medicine Wheel Dental's Notice of Privacy Practices.

Patient name _____

Signature _____ Date _____