Mettler & Griego
Family Dentistry

P623.487.4870
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www.mettlergriego.com

Patient Information:

Patient First Name: _____Middle: ____ Last: _____

Preferred Name: _____ Marital Status: Married / Single / Divorced

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

Cell Phone: _____ Work Phone: _____

Home Phone: _____ **Email Address:** _____ *May we contact you by email?* ***Yes No***

What is the best way to contact you? **Phone / Email / Text** @ Time of Day? **AM / PM**

Patient Social Security #:_____-___-_____ Patient Date of Birth: _____ Sex: **M / F**

Emergency Contact: _____ Phone: _____

How did you hear about us?

_____

**If patient is under the age of 18, Parent or Guardian please fill out below:*

Parent/Guardian Name: _____

Date of Birth: _____ Social Security #_____-____-_____

Insurance Information:

Do you have Dental Insurance? **Yes / No**

Primary Insurance:

Subscriber Name: _____

Subscriber SSN: _____

Date of Birth: _____

Secondary Insurance:

Subscriber Name: _____

Subscriber SSN: _____

Date of Birth: _____

Relationship to Subscriber: **Self / Spouse / Child / Other** Relationship to Subscriber: **Self / Spouse / Child / Other**

Employer Name: _____ Employer Name: _____

Employer Phone #_____ Employer Phone #_____

Insurance Company: _____ Insurance Company: _____

Insurance Group #_____ Insurance Group #_____

Insurance Phone #_____ Insurance Phone #_____

Insurance Address: _____ Insurance Address: _____

Please present insurance card and Driver's License

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Sleep Health Questionnaire:

Have you ever been told you stop breathing while asleep? *

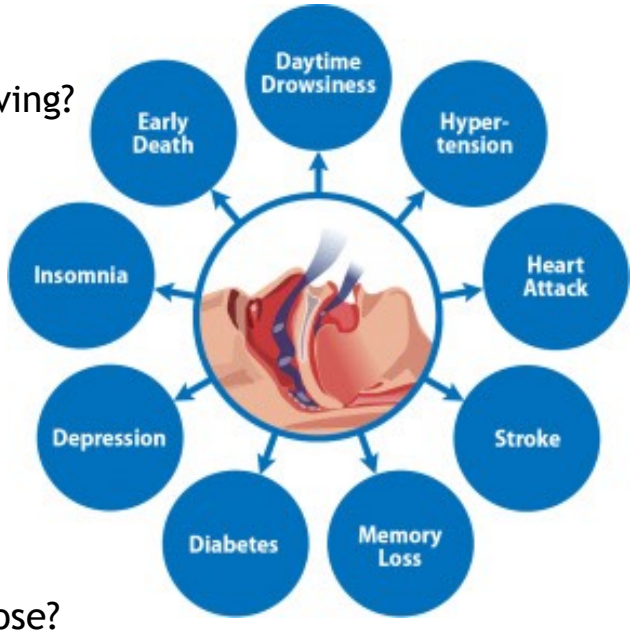
☐ Yes ☐ No

Have you ever fallen asleep or nodded off while driving?

☐ Yes ☐ No

Have you ever woken up suddenly with shortness of breath, gasping, or with your heart racing?

☐ Yes ☐ No



Do you feel excessively sleepy during the day? *

☐ Yes ☐ No

Do you snore or ever been told you snore? *

☐ Yes ☐ No

Have you had weight gain and found it difficult to lose?

☐ Yes ☐ No

Have you taken medication for, or been diagnosed with high blood pressure?

☐ Yes ☐ No

Do you kick or jerk your legs while sleeping?

☐ Yes ☐ No

Do you feel burning, tingling, or crawling sensations in your legs when you wake up?

☐ Yes ☐ No

Do you wake up with headaches during the night of in the morning? *

☐ Yes ☐ No

Do you have trouble falling asleep?

☐ Yes ☐ No

Do you have trouble staying asleep once you fall asleep? *

☐ Yes ☐ No

Have you in the past or recently completed a Sleep Study? *

☐ Yes ☐ No

Have you been diagnosed with Obstructive Sleep Apnea? *

☐ Yes ☐ No ***If yes, are you currently using a **CPAP Machine** or an **Oral Sleep Appliance**?*

Yes / No

Mettler & Griego Family Dentistry

Office Policies:

We feel it is important to share policies of our practice with you. We ask you read this thoroughly, initial by each section, then sign and date to indicate you understand and agree to comply with our policies.

_____ **COMMITMENT TO TREATMENT POLICY** We believe all treatment started should be completed. Incomplete treatment can lead to problems, complications, further disease, and more expenses. Rest assured we will never move forward with treatment without your consent

_____ **COMMITMENT TO APPOINTMENT POLICY** We reserve time for each patient in our practice and do our best not to keep patients waiting. An appointment placed in our schedule is time we have committed for you and is a bond of trust we will be here to serve you and you will be present for your appointment. We ask for mutual respect of each other's time. If you do need to change an existing appointment, please call during regular business hours Monday-Friday to speak with a team member 48 business hours in advance to avoid cancellation fees. Please note our answering machine does not accept appointment cancellations or changes. ***Failure to give 48 hours' notice may result in a $50 cancelation fee***.

_____ **INSURANCE POLICY** Our office does not diagnose, render treatment, or establish fees according to any insurance tables or allowances. Our fees are based on the care, skill and judgment of the professionals delivering the services, and the cost of operating a dental office dedicated to excellence. Please remember we work 100% for you, not your insurance company. We submit all insurance claims on your behalf and your dental plan may only cover charges for the least expensive results. We refuse to compromise our standards by offering anything less than the complete care you deserve. Please understand you are ultimately responsible for any amounts not covered by your plan regardless of the estimates presented.

_____ **COMMITMENT TO FINANCIAL AGREEMENT POLICY** We believe we have a responsibility to you to use our best professional care, skill and judgment in planning and delivering your dental treatment. We can only fulfill this mission through a bond of trust with you to pay for services. We

will do our best to make you aware of all fees before treatment is rendered. Mettler & Griego Family Dentistry will make every effort to collect the appropriate payment from our contracted insurance plans for all billable services. Some services may not be covered or not paid in full by your insurance carrier due to various reasons. There is no guarantee of insurance benefits or coverage and all insurance fees presented are only an estimate. Mettler & Griego Family Dentistry's UCR fees presented will be honored for 6 months. All balances due are to be paid in full within thirty (30) days from the date of services rendered. Should your account exceed thirty days, one and one-half percent (1.5%) interest per month (18% per year) will be charged. Account balances exceeding 90 days will be sent to collections. If in the event of default on your account, you acknowledge you will be responsible for collection fees and/or legal fees as may be required to complete the collection of your past due account.

Patient Signature *Date*

Parent/Guardian Signature *Date*

Mettler & Griego Family Dentistry

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement. The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. Implementation of HIPAA requirements officially began April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complex text is available in the office. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as a patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as necessary and appropriate for your care. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We do this by telephone, e-mail, text messaging, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be sold or shared for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We many change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

By signing this form, I have received a copy of this office's notice of privacy practices.

_____

Patient Signature *Date*

_____

Parent/Guardian Signature *Date*

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Release Authorization

The information to be released includes the following information and records in Mettler & Griego Family Dentistry's possession, custody, or control regarding the Patient:

- ☐ Radiographs (Most recent BWX, Pano, Full Mouth Series)
- ☐ Periodontal Charting
- ☐ Full Dental Records
- ☐ All of Patients protected health information (PHI), unless excepted
- ☐ Financial Records/Obligation/Estimates of Treatment

The information described above may be released to: (Check the appropriate category)

- ☐ Spouse/Partner
- ☐ Parent/Guardian
- ☐ Family Member

- ☐ Self
- ☐ Physician/Hospital
- ☐ Insurance Co.
- ☐ Attorney
- ☐ Power of Attorney
- ☐ Other: _____

Release To: (Please fill in who will be receiving/accessing your dental records:

Name: _____ Phone: _____

Email: _____ Relationship to you: _____

I understand this authorization is voluntary and I may refuse to sign this authorization. I further understand my health care will not be affected if I do not sign this form.

_____

Patient Signature *Date*

_____

Parent/Guardian Signature *Date*