

PATIENT INFORMATION

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

TODAY'S DATE: _____

PATIENT'S 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 _____

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 # (PLAN, POLICY #): _____

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		PAST	CURRENT	NO
ALLERGIES TO MEDICATIONS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	URINARY OR GENITAL PROBLEMS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
IF CURRENT PLEASE STATE				VENEREAL/SEXUALLY TRANSMITTED DISEASE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ALLERGIES	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	IF CURRENT, WHAT TYPE			
HIVES/SKIN RASHES	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	KIDNEY OR BLADDER PROBLEMS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HEART OR CIRCULATION PROBLEMS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	EXCESSIVE URINATION,PAIN,POOR CONTROL	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HIGH/LOW BLOOD PRESSURE (CIRCLE)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	DECREASED FORCE OF URINATION	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HEART MURMUR	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	BLOOD IN URINE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
MITRAL VALVE PROLAPSE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PROSTATE PROBLEMS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HEART ATTACK	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	WOMEN: ARE YOU PREGNANT?	YES	NO	
STROKE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	NUMBER OF PREGNANCIES			
FAINTING SPELLS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	NUMBER OF LIVE BIRTHS			
BLOOD TRANSFUSION	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	DIFFICULTIES WITH CHILDBIRTH?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
PROLONGED BLEEDING FROM CUTS/EXTRACTIONS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PMS (MODERATE OR SEVERE?)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ANEMIA, BLOOD DISORDERS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	NEUROLOGICAL PROBLEMS			
HIV, ARC, AIDS (CIRCLE)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	EPILEPSY/CONVULSIONS OR SEIZURES	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
SWOLLEN ANKLES	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	BLACKOUTS OR FAINTING SPELLS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HEART PALPITATIONS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	NUMBNESS/TIGHTNESS SENSATIONS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
BRUISE EASILY	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	TREMORS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
RESPIRATORY/BREATHING PROBLEMS				EYE PROBLEMS			
ASTHMA/HAY FEVER	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	CONTACT LENSES/GLASSES	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
SINUS PROBLEMS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	EYE PAIN	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
LUNG DISEASE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	BLURRED OR DOUBLE VISION	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
TUBERCULOSIS (T.B.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	EAR PROBLEMS			
CHEST PAINS, OR SHORTNESS OF BREATH W/EXTRACTIONS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	DIFFICULTY HEARING	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
PNEUMONIA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PAIN IN/AROUND EARS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CHRONIC COUGH	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	RINGING OR HIGH PITCHED SOUNDS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
EMPHYSEMA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	EAR INFECTIONS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
GASTRO INTESTINAL PROBLEMS				DIZZINESS OR LOSS OF BALANCE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
UNEXPLAINED WEIGHT LOSS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	THROAT PROBLEMS			
CONSTIPATION/ DIARRHEA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SWALLOWING PROBLEMS OR CHRONIC HOARSENESS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
JAUNDICE/LIVER PROBLEMS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	FREQUENT SORE THROAT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CHRONIC ABDOMINAL PAIN	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	ENDOCRINE PROBLEMS			
COLITIS/ULCER/NERVOUS STOMACH	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	EXCESSIVE THIRST	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
DIFFICULTY SWALLOWING	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	DIABETES	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
LOSS OF APPETITE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	HYPOGLYCEMIA/LOW BLOOD SUGAR	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HEMORRHOIDS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				

OFFICE FINANCIAL POLICY

WELCOME TO OUR OFFICE

WE APPRECIATE YOUR SELECTION OF OUR OFFICE TO SERVE YOUR DENTAL HEALTH NEEDS. OUR GOAL IS TO PROVIDE THE VERY BEST POSSIBLE DENTAL CARE SO THAT YOU MAY ACHIEVE OPTIMAL DENTAL HEALTH THROUGHOUT YOUR LIFETIME.

OFFICE HOURS

OUR REGULAR OFFICE HOURS ARE 8:30 A.M. TO 12:00 P.M. AND 1:30 P.M. TO 4:00 P.M. MONDAY- THURSDAY. THE OFFICE IS CLOSED ON MAJOR HOLIDAYS AS WELL AS AT TIMES WHEN THE DOCTOR AND STAFF ARE ATTENDING CONTINUING EDUCATION PROGRAMS TO MAXIMIZE OUR KNOWLEDGE OF THE LATEST DEVELOPMENTS SO THAT WE MAY BETTER SERVE YOU.

FEES AND PAYMENT POLICY

IN AN EFFORT TO KEEP DENTAL COSTS DOWN WHILE MAINTAINING A HIGH LEVEL OF PROFESSIONAL CARE, PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED. FEES MAY BE PAID AS FOLLOWS:

1. CASH
2. PERSONAL CHECK
3. MONEY ORDER
4. VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS
5. CARE CREDIT

YOU AGREE TO PAY IN FULL AS SERVICES ARE RENDERED, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE WITH THE OFFICE.

ACCOUNTS LEFT OUTSTANDING MORE THAN 60 DAYS FROM A TREATMENT DATE WILL BEAR INTEREST AT 1 ½% PER MONTH OR 18% ANNUALLY.

ALL MAJOR TREATMENT AND TREATMENT INVOLVING A LABORATORY PROCEDURE, WILL REQUIRE A DOWN PAYMENT OF AT LEAST ½ OF THE TREATMENT PROCEDURE COST. THE OTHER HALF IS DUE UPON COMPLETION OF THE PROCEDURE.

INSURANCE

IF YOU HAVE INSURANCE, WE WILL HELP YOU TO DISCOVER THE COVERAGE YOU HAVE AVAILABLE AND UTILIZE YOUR BENEFITS BY SUBMITTING AN INSURANCE CLAIM ON YOUR BEHALF. WE ASK THAT YOU ASSIGN YOUR INSURANCE BENEFIT TO YOURSELF. WE CANNOT ACCEPT PERSONAL INSURANCE AS PAYMENT.

PROFESSIONAL CARE IS PROVIDED TO YOU, OUR PATIENT, AND NOT TO AN INSURANCE COMPANY. WE REQUEST THAT DENTAL INSURANCE BENEFITS BE PAID DIRECTLY TO YOU. WE WILL HELP IN EVERY WAY WE CAN IN FILING YOUR CLAIM AND HANDLING INSURANCE QUESTIONS FROM OUR OFFICE ON YOUR BEHALF.

APPOINTMENTS

IN THE EVENT OF A BROKEN APPOINTMENT, I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR THE TIME I HAVE RESERVED, UNLESS I PROVIDE 48 HOURS NOTICE (EMERGENCIES WILL BE DISCUSSED ON A CASE BY CASE BASIS). THE COST FOR A BROKEN APPOINTMENT IS 1/3 OF THE TOAL FEE SCHEDULED FOR THAT PARTICULAR APPOINTMENT.

PATIENT'S 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 than 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 _____

LUMINEERS® BY CERINATE® SMILE EVALUATION

A Simple Quiz to Help You Obtain the Smile You've Always Wanted

NO PAIN—YOU DON'T EVEN NEED AN ASPIRIN.

THE MOST SIGNIFICANT COSMETIC ADVANCEMENT...EVER!

Hold a mirror 12"–14" from your face. Smile to show your teeth. Take the time to observe your teeth carefully, then answer the following questions. If you are not happy with the appearance of your teeth, ask your dentist how LUMINEERS can improve your smile.

1 Do you like the appearance of your teeth; your smile? Yes No
If not, explain _____



STAINED AND CHIPPED

2 Are your teeth all in alignment (straight)? Yes No
If not, explain _____



SPACES

3 Do you have spaces that you don't like? Yes No
If yes, explain _____

4 Do you like the color of your teeth? Yes No
If not, explain _____



CALCIFICATION STAINS

5 Do you like the shape of your teeth? Yes No
If not, explain _____



FANGED TEETH

6 Are your teeth...
chipped? _____ protruding? _____ hidden? _____

7 Are your teeth wearing on the biting surfaces? Yes No
If yes, explain _____



STAINED AND CROOKED TEETH

8 Are there old fillings or dental work you don't like looking at? Yes No
If yes, explain _____



PORCELAIN CROWNS

9 What would you like to change the most in the appearance of your teeth?

10 How would you like your teeth to look?



BEAUTIFUL SMILE



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