Dr. George Christakos Family Dentistry

PATIENT INFORMATION

LAST NAME	FIRST	MI	DATE OF BIRTH	AGE	**SOCIAL SECURITY NUMBER**
HOME ADDRESS	APT/UNIT #	CITY	STATE	ZIP CODE	**HOME PHONE** ( )

NICKNAME	REFERRED BY
MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐PARTNERED ☐ OTHER	OTHER FAMILY MEMBERS THAT ARE PATIENTS OF DR. CHRISTAKOS

EMPLOYMENT STATUS ☐ EMPLOYED ☐ FULL TIME STUDENT ☐ UNDER 18YRS OLD ☐ OTHER IF STUDENT, SCHOOL?______________________________STATE___________	IF A CHILD, WHO BROUGHT YOU (NAME)?	RELATIONSHIP TO CHILD
YOUR EMPLOYER/OR RESPONSIBLE PARTIES EMPLOYER		**WORK PHONE** ( )

EMPLOYERS ADDRESS	CITY	STATE	ZIP CODE	**CELL PHONE** ( )

PERSONAL E-MAIL ADDRESS	DRIVERS LICENCE #	STATE

EMERGENCY CONTACT OR LEGAL GUARDIAN INFORMATION

LAST NAME, FIRST NAME	RELATIONSHIP TO PATIENT	TELEPHONE ( )

PRIMARY INSURANCE COMPANY INFORMATION

INSURANCE COMPANY NAME		EMPLOYER		GROUP/PLAN OR POLICY NUMBER
INSURANCE ADDRESS	CITY	STATE	ZIP CODE	INSURANCE PHONE NUMBER ( )
EMPLOYEE NAME			DATE OF BIRTH	
ID NUMBER OR SOCIAL SECURITY # (NEEDED FOR FILING DENTAL CLAIMS)			RELATIONSHIP TO PATIENT	

SECONDARY INSURANCE COMPANY INFORMATION

INSURANCE COMPANY NAME		EMPLOYER		GROUP/PLAN OR POLICY NUMBER
INSURANCE ADDRESS	CITY	STATE	ZIP CODE	INSURANCE PHONE NUMBER ( )
EMPLOYEE NAME			DATE OF BIRTH	
ID NUMBER OR SOCIAL SECURITY # (NEEDED FOR FILING DENTAL CLAIMS)			RELATIONSHIP TO PATIENT	

Assignment of benefits/authorization of release medical information/consent to treatment

I HEREBY ASSIGN ALL DENTAL BENEFITS TO WHICH I AM ENTITLED TO DR.GEORGE CHRISTAKOS IN THE EVENT THEY FILE INSURANCE ON MY BEHALF. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. IN THE EVENT MY ACCOUNT BECOMES DELIQUENT AND IS THEREFORE IN DEFAULT OF PAYMENT, I ACCEPT RESPONSIBILITY FOR THE PRINCIPLE AMOUNT OWEING AS WELL AS ALL RESPONSIBLE COSTS ASSOCIATED WITH THE COLLECTION OF THIS DEBT. INTEREST MAY BE CHARGED AT A RATE OF 1.5% PER MONTH (18%APR) FOR UNPAID BALANCES OVER 90 DAYS OLD. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF SAID BENEFITS. A COPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I DO HEREBY CONSENT TO SUCH TREATMENT BY THE AUTHORIZED PERSONNEL OF DR. GEORGE CHRISTAKOS. THIS CONSENT IS INTENDED AS A WAIVER OF LIABILITY FOR SUCH TREATMENT EXCEPT ACTS OF NEGLIGENCE.

AUTHORIZED SIGNATURE	**TODAY'S DATE**

Dr. George Christakos Family Dentistry

Previous Dentist	PHONE ( )	LAST DENTAL CLEANING	LAST DENTAL X-RAYS

Why have you come to the dentist today?

____

Are you currently in pain? Yes _____No______

Do you require antibiotics before dental treatment?
Yes___ No ____

Do you or have you experienced pain or discomfort in your Jaw (TMJ/TMD)? Yes _____No_____

Do you get frequent headaches? Yes _____No_____

Your current dental health is: Good ___ Fair ___Poor ____

Do you floss daily? Yes____No___

Do you Brush daily? Yes ___No___

What type of toothbrush do you use? Electric ___Manual___

Are the bristles? Soft______ Medium_____ Hard _______

Do your gums bleed when you brush your teeth?
Yes ____No____

Have you ever had periodontal disease? Yes ____No____
Have you ever had periodontal treatment? Yes ____No____

Do you have a personal physician? Yes ____No____

Physician's Name____

Address: ____

Phone # (______) ____________Date of last visit____________

Are you under the care of a physician? Yes ___No____

Please explain
____

Do you smoke or use tobacco of ANY form? _______________

If yes, how long ________Years

Would you like to quit? Yes ______No________

WOMEN

Are you taking birth control? Yes _______No_______

Are you pregnant? Yes ___No______ Week#______

Are you nursing? Yes ______No____

*If you **CURRENTLY HAVE** or have **HAD** any of the following conditions please indicate with a check mark.*

____AIDS/AND OR HIV	____DIABETES	____HIGH/LOW BLOOD PRESSURE	____SICKLE CELL DISEASE
____ANEMIA	____EMPHYSEMA	____HOSPITIALIZED FOR ANY Reason? ______________	____SINUS TROUBLE
____ARTIFICIAL HEART VALVE	____GLAUCOMA	____LUPUS	____STROKE
____ARTIFICIAL JOINTS	____HAY FEVER	____MVP	____THYROID DISORDER
____ASTHMA-Due ____________	____HEART MURMUR	____PACE MAKER	____TUBERCULOSIS (TB)
____BLOOD TRANSFUSION	____HEART SURGERY	____RADIATION TREATMENT	____ULCER
____CANCER	____HEMOPHILIA	____RHEUMATIC FEVER	____YELLOW JAUNDICE
____CHRONIC COUGH	____HEPATITIS __A___B___C	____RHEUMATISM	
____CONGENITAL HEART DEFECT	____HERPES		

ALLERGIES~ Please circle:

Aspirin Codeine Erythromycin Penicillin Sulfa Tetracycline Local Anesthesia Latex

ALLERGIES NOT LISTED:____

Please list your medications:____

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I also authorize the dental staff to perform the necessary dental services I may need.

~48 hour notice is required to cancel or reschedule an appointment.
~There will be a $50.00/$100.00 charge(s) if proper notice is not given to cancel or reschedule an appointment.
~Payment is due in full at the time of treatment unless prior arrangements have been made.
~If you have insurance- I hereby authorize payment to the named dentist of group benefits otherwise payable to me.

____
Patients name (Please print)

______________________________*Date*_________
Signature of Responsible party or Patient

PAYMENT POLICIES

Welcome to Dr. George Christakos office. We are happy to further extend our services by filing your insurance(s) claim for you. **Please initial next to your payment choice.**

_____ Self-Pay – Payment is due in full at the time of service. In the event you are unable to pay the balance in full, please advise us prior to the time of services. Please be advised that we are not a credit grantor, and therefore, failure to maintain these arrangements may result in the placement of your account with an agency or attorney for collection.

_____ Primary/Secondary Insurance – As a courtesy to our patients we will bill your insurance(s). We assume payment of insurance benefits is not forthcoming on charges older than thirty days. Charges outstanding for more than thirty days from the date of filing will be due in full from you regardless of the type of insurance involved. Co-pays, deductibles and percents not paid by insurance are to be paid by Check, Cash, MasterCard, Visa, Discover and CareCredit**. All payments are due at time of service.**

If you are interested in CareCredit ask the front desk personnel for more information.

Please be aware that you will remain financially responsible for any and all services and supplies received regardless of the payment option selected above. In the event your account becomes delinquent and is therefore in default of payment, the patient, legal guardian, or admitting parent will be responsible for the principal amount owed and all reasonable costs associated with the collection of this debt, including, but not limited to, collection service fees, attorney's fees, all court costs, and additional legal expenses associated with recovery of debt.

Thank you for allowing us the opportunity to service you. Please sign and date this form. If you have any questions, please ask for our assistance.

_________________________________ _________________________

Patient/Guardian Signature Date

Notice of Patient Privacy Practices

DR. CHRISTAKOS LEGAL DUTY

Dr. George Christakos is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Dr. George Christakos uses your health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide. For example, Dr. George Christakos may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Dr. George Christakos may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposed, and for emergencies. We may provide de-identified information for research studies. We also provide information when required by law.

In any other situation Dr. George Christakos policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Dr. George Christakos may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in a common area of our clinic. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. Dr. George Christakos will consider all such requests on a case-by-case basis, but the Company is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Dr. George Christakos may have violated your privacy rights of if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our HIPAA Compliance Office at the address listed below. You may also send a written complaint to the US Department of Health and Human Services.

I have read and fully understand Dr. George Christakos Notice of Patient Privacy Practices. I understand that Dr. Christakos may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict operations if I notify the Company in writing. I also understand that Dr. Christakos will consider request for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Dr. Christakos Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the Company in writing at any time.

Patient/Guardian signature: ______________________________________Date_________

If you require further information on Dr. George Christakos health information practices, or if you have a complaint, please contact the following office:

Dr. George Christakos Family Dentistry
8573 E. Princess Dr., Suite 201
Scottsdale, Arizona 85255
480-585-1725

PATIENT INFORMATION CONSENT FORM

DESIGNATED INDIVIDUALS AUTHORIZATION

PATIENT NAME:	DATE

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Parties:

Spouse: ____

Name: ______________________________ Relationship:______________________________

Name: ______________________________ Relationship:______________________________

Name: ______________________________ Relationship:______________________________

______________________________ ______________________________
Patient/Guardian Signature Date

Assignment of Benefits Agreement

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, though, that the contract regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.

- We require you to sign this form and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.

- We require you to pay the copayment, which is the amount not covered by your insurance company, at the time we provide services.

- Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 90 days, we ask you to pay the balance due at that time. You will be responsible for seeking reimbursement from your insurance company at that time.

- Our office does not guarantee that your insurance company will pay for the treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for the full amount at that time.

- Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

By signing this I also authorize release of information to my insurance company to assist in payment of my claims.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO DR GEORGE CHRISTAKOS FAMILY DENTISTRY/GEORGE T. CHRISTAKOS, DDS THIS AGREEMENT SHALL BE IN FORCE AND EFFECTIVE UNTIL REVOKED BY THE PATIENT OR REPRESENTATIVE SIGNING THIS AGREEMENT.

__________________________ ___________________________________ _________

Print Name   Signature of Patient/Responsible Party   Date