CENTER FOR DENTAL REHABILITATION

GENERAL AND HOSPITAL DENTISTRY

SPECIALIZING IN TREATMENT OPTIONS
FOR PATIENTS WITH SPECIAL NEEDS.
WEBSITE: WWW.DRMTOAL.COM

MAUREEN M. TOAL, DMD

LAS PALMAS MEDICAL & DENTAL PLAZA
16620 NORTH 40TH STREET, BUILDING F
PHOENIX, ARIZONA 85032
602 485-0505
FAX: 602 485-5068

Welcome to the Center for Dental Rehabilitation!

The relationship we establish with each and every one of our patients is viewed with a deep sense of responsibility. A major part of that responsibility is to help our patients get back to receiving regular dental care. Once a treatment plan has been established, our goal is to restore optimum dental health in a few, well-planned appointments at your convenience.

During your first visit, you will receive a thorough examination of your mouth, teeth, gums and soft tissue. The examination will include necessary diagnostic radiographs to accurately determine the condition of your oral health. Following a careful diagnosis, we will consult with you to insure there is a full understanding of your dental needs, the procedures recommended and the possible consequences if the necessary dentistry is not addressed.

Please complete and sign the enclosed forms and bring them to your appointment. If you have dental or medical coverage, we will be happy to submit claims for your reimbursement. Therefore, please remember to bring your complete insurance information.

Thank you for choosing the Center for Dental Rehabilitation to serve you. We look forward to working with you.

Sincerely,

Dr. Maureen M. Toal and Staff

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

Patient Information

Patient Name: _____ Date: _____
Last First Middle

(If patient is full time student, fill in school name): _____

Address: _____

Home Phone: _____ Birthdate: _____ Social Security # _____

If patient is a minor, give parents' or guardians' name: _____

Name of nearest relative not living with you: _____ Phone: _____

Complete Address: _____

Responsible Party Information

Name: _____
Last First Middle Marital Status

Residence: _____
Street City State Zip

Mailing Address: _____

How Long at this address? _____Home Phone: _____ Work Phone: _____

Previous address (if less than 3 years): _____

Social Security #: _____ Relationship to Patient _____

Employer: _____ Occupation: _____No. Years Employed: _____

Employer Address: _____

Spouse's Name: _____

Employer: _____ Occupation: _____No. Years Employed_____

Employer Address: _____

Social Security #: _____ Birth Date: _____ Work Phone: _____

Insurance Information

Insured's Name: _____ Relationship to Patient: _____

Insurance Co.: _____ Group No.: _____

Insurance Co. Address: _____
Street

_____ Ph.#:_____

Is policy connected with your union? Yes ____ No ____ Name of Union: _____ Local No.: _____

Do you have dual coverage? Yes ____ No ____ If yes: Please complete the following secondary insurance information.

Insured's Name: _____Insured's Soc. Sec. # _____

Insurance Co: _____ Group No: _____ Local No:_____

Insurance Co. Address: _____
Street City State Zip

Ph.#: _____

Insured's Employer: _____ Ph.#: _____

Address: _____
Street City State Zip

1. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 ½ % finance charge (18% APR) may be added to my account, in addition to any collection charged.
2. I understand that where appropriate, credit bureau reports may be obtained.
3. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Signature: _____ Date: _____

FOR OFFICE USE: Reviewed by Dr. _____ Date: _____

Medical Information

1. Ht: _____ Wt: _____
2. Are you allergic to any medications or anesthetics: _____
3. Non-drug allergies (food, environmental, etc): _____
4. Name, address, phone number of primary care physician _____
5. Date of last physical examination: _____
6. Please list previous surgeries and or hospitalizations for any serious illnesses or accident: Year

_____ _____
_____ _____
_____ _____
_____ _____

7. List any medications you are taking on a daily basis.

Name	Dose/ Frequency	Reason For Taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

8. Are you currently taking St. John's Wort? ( ) Yes ( ) No Are you currently taking Meridia? ( ) Yes ( ) No
9. List any non-prescription or over the counter medications you are now taking including, herbal/dietary supplements.

_____

10. Indicate which of the following you have had or have at present. Check yes or no to each item.

	Yes	No		Yes	No
Heart Disease	( )	( )	Kidney Disease	( )	( )
Heart Murmur	( )	( )	Seizures/Epilepsy	( )	( )
High Blood Pressure	( )	( )	Cancer	( )	( )
Stroke	( )	( )	Liver Disease	( )	( )
Asthma	( )	( )	Hepatitis	( )	( )
Emphysema	( )	( )	HIV and/or AIDS	( )	( )
Shortness of Breath	( )	( )	Cold Sores/Fever Blisters	( )	( )
Diabetes	( )	( )	Psychiatric Treatment	( )	( )
Developmentally Disabled	( )	( )			
11. Do you drink Alcohol?	( )	( )			

How Often _____
12. Do you smoke? ( ) ( )
How many packs/day? _____
13. If under 18 years of age, are your immunizations current? ( ) Yes ( ) No
14. How would you describe your general health? ( ) Good ( ) Fair ( ) Poor
15. Any other health problems we need to be aware of? _____

Dental Information

Are any of your teeth sensitive to: ( ) Hot ( ) Cold ( ) Sweets ( ) Pressure
Yes ( ) No ( ) Do you know of any: inflamed areas, growths, sore spots, unhealed injuries, in or around your mouth?
Yes ( ) No ( ) Have you noticed any loosening of your teeth?
Yes ( ) No ( ) Does food tend to become caught between your teeth?
Yes ( ) No ( ) Do you suffer from pain and/or swelling of your gums?
Yes ( ) No ( ) Do your gums often bleed when you brush your teeth?
Yes ( ) No ( ) Have you ever had any unfavorable reaction from a local anesthetic?
Yes ( ) No ( ) Are you missing any teeth? Have they been replaced? _____
Yes ( ) No ( ) Do you ever have bad breath or a bad taste in your mouth?
Yes ( ) No ( ) Have you ever had a local anesthetic (Novocain, etc.)?
Yes ( ) No ( ) Do you wear any removable appliances?

Habits:

Yes ( ) No ( ) Do you hold foreign objects with your teeth? (such as pencils, pipe, pins, nails, fingernails)
Yes ( ) No ( ) Do you bite your lips or cheeks regularly?
Yes ( ) No ( ) Do you clench or grind your teeth while awake or asleep?
Yes ( ) No ( ) Are you a mouth breather while awake or asleep?

Problems of the Jaw:

Yes ( ) No ( ) have you experienced clicking of the jaw?
Yes ( ) No ( ) Have you experienced Pain? (Joint, ear, side of face)
Yes ( ) No ( ) Have you experienced difficulty in opening or closing?
Yes ( ) No ( ) Have you experienced difficulty in chewing?
Yes ( ) No ( ) Have you ever had Orthodontic treatment?
Yes ( ) No ( ) Have you ever had Oral Surgery?
Yes ( ) No ( ) Have you ever had Periodontal treatment?

MEDICATION LIST

Patient Name: _____ DOB: _____ Date: _____

Primary Care Physician Name and Phone #: _____

Pharmacy Name and Phone #: _____

	Medication	Dosage	How often?	What do you take this for?
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

Medication List
Continuation Page

13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				
21.				
22.				
23.				
24.				
25.				
26.				
27.				
28.				

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OUR FINANCIAL POLICY

Thank you for choosing us as your dental health care provider. We ask that all patients read and sign our Financial Policy as well as complete our patient information form, prior to your appointment. If you have any questions or concerns regarding our financial policy, please do not hesitate to ask.

Payment is due at the time services are rendered. We accept cash, checks and for your convenience, most major credit cards. We will be happy to assist you in the processing of any insurance claims for your reimbursement.

Please understand:

- Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to the contract. Our relationship is with you, not the insurance company.
- All charges are your responsibility whether your insurance company reimburses you or not. Not all services are a covered benefit. It is your responsibility to inquire about your benefits.
- If your insurance company does not reimburse you within 30 days, we suggest you contact the carrier to continue with the reimbursement processing.

Please note, unless a cancellation is received at least 48 hours in advance, you may be charged for missed appointments. Please call our office if you need to reschedule an appointment.

We encourage you to communicate any financial problems or concerns, so that we can assist you in the management of your account.

We appreciate your confidence in us and look forward to serving you.

_____ _____

Signature (patient/guardian) Date

_____ _____

Witness Date

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HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information (PHI). These rights have been given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent form, I authorize the **Center for Dental Rehabilitation** to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. insurance company)
- Day-to-day healthcare operations of the practice (email/ text reminders/ confirmations of appointments via online services)

I have also been informed of, and given the right to review a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that the **Center for Dental Rehabilitation** reserves the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected heath information is used and disclosed to carry out treatment, payment, and healthcare operations. You are not required to agree to these restrictions however, if you do agree, you are then bound to comply with these restrictions.

I understand that I may revoke this consent in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this_____day of_____,20_____.

Patient Name Printed:_____

Signature:_____

Relationship to patient:_____

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Maureen M. Toal, D.M.D.

Center for Dental Rehabilitation

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ acknowledge that I received a copy of the "Notice of Privacy Practices" from Dr. Maureen M. Toal.

This notice describes how Dr. Maureen M. Toal may use and disclose my health information, certain restrictions on the use of my healthcare information, and rights I may have regarding my protected health information.

I authorize Dr. Maureen M. Toal and/or staff members at the Center for Dental Rehabilitation and its agents to photograph, videotape, audio record, televise, duplicate, and/or otherwise record my image, voice, and likeness, I understand that Dr. Maureen M. Toal will own these recordings.

This notice also informs the patient that Dr. Maureen M. Toal will not release ANY personal information for marketing purposes, or to related organizations.

This notice takes effect January 1, 2006 and will remain in effect until we replace it.

Please list any person/persons that you authorize Dr. Toal to discuss your financial, medical and dental treatment with.

_____ _____
Name and relationship to patient Date

_____ _____
Name and relationship to patient Date

_____ _____
Signature of Patient (or Patient Representative) Date

_____
Relationship to Patient

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HIPAA PRIVACY FORM 1

Notice of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

QUESTIONS AND COMPLAINTS

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

If you want more information about our privacy practices or have questions or concerns, please contact us.

Contact Officer: Chad Martin

Telephone : 602 485 0505 Fax: 602 485 5068

E-mail: main@drmtoal.com

Address: 16620 N. 40th Street Building F, Phoenix, AZ 85032

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU 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 (04/14/03), 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 our office.

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 practicably 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 contacting our office at (602) 485-0505 or main@drmtoal.com. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending a letter addressed to the **Center for Dental Rehabilitation**, 16620 N. 40th St., Bldg. F, Phoenix, AZ 85032. If you request copies, we will charge you $0.25 for each page, $25.00 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.

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 operations 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 Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Submit