Desert Breeze Dentistry
Caring for People, One Smile at a Time

Patient Information

Patient Name _____ Today's Date: _____
Last First

Birth Date _____ Gender _____ Family Status: ☐ Single ☐ Married ☐ Child ☐ Other

Social Security Number _____ Driver License Number _____ State _____

Address _____
Street Apartment # City State Zip

Cell Phone _____ Can we text your cellphone? ☐ YES ☐ NO

E-MAIL _____

Spouse or Responsible Party Information

Name _____ Relationship _____
Last First

Birth Date _____ Gender _____ Family Status: ☐ Single ☐ Married ☐ Child ☐ Other

Social Security Number _____ Driver License Number _____ State _____

Address _____
Street Apartment # City State Zip

Cell Phone _____ Can we text cellphone? ☐ YES ☐ NO

Can we discuss treatment with a spouse or responsible party? ☐ YES ☐ NO

Employment Information

Employer Name _____ Occupation _____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient ☐ driving by ☐ google ☐ Yelp ☐ School ☐ Work ☐ Other

Name of person or office referring you to our practice: _____

Desert Breeze Dentistry
Caring for People, One Smile at a Time

Consent for Services

Patient Initials

_____I understand hereby authorizing Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs.

_____I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

_____ I understand that as a condition of my treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

_____I understand that all emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are performed.

_____I understand that if I carry dental insurance, that all fees for treatment are only an estimate and that I am not bound to receive services /treatment. I understand that these fees are ESTIMATES only. Desert Breeze Dentistry can only estimate regarding my insurance benefits based on the information that I provided.

_____I understand that Desert Breeze Dentistry will bill my insurance a courtesy on my behalf. If for any reason Desert Breeze Dentistry has not been paid in full by my insurance within 90 days of the date of service; **the balance in full becomes my responsibility**.

_____ I agree to be responsible for deductible, copay and all charges for dental services and materials not covered or not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a a portion of such charges. To the extent permitted by law, I consent to Desert Breeze Dentistry's use and disclosure of my protected health information to utilize payment activities in connection with insurance claims.

_____I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the Desert Breeze Dentistry, Feras Ziadat, D.M.D.

_____ I understand that Desert Breeze Dentistry requires **48 hours cancellation notice** prior to my scheduled arrival date, otherwise Desert Breeze Dentistry will charge me a **$50 CANCELLATION fee or NO SHOW fee.**

_____ In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to Desert Breeze Dentistry, at the time said services are rendered.

_____I grant my permission to you or your assignee, to speak with me at my phone number provided to discuss matters related to this form.

_____I grant my permission to you or your assignee, to speak with my spouse or responsible party at phone number provided to discuss matters related to my care.

_____I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian:_____**Date**:_____

Relationship to patient_____

Desert Breeze Dentistry
Caring for People, One Smile at a Time

NOTICE OF PRIVACY PRACTICES (HIPAA)

PATIENT/GUARDIAN — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I_____ , have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Any correspondence should be addressed to:
Desert Breeze Dentistry
1720 E Warner Rd # 5,
Tempe, AZ 85284

Signature:_____ **Date:** _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ADVISE US IF YOU WANT A COPY.

CANCELLATION POLICY

We require **48 hours cancellation notice** prior to your scheduled arrival date; otherwise we will charge you a **$50 cancellation fee**.

Desert Breeze Dentistry
Caring for People, One Smile at a Time

GENERAL DENTISTRY INFORMED CONSENT

1. DRUGS AND MEDICATIONS: I understand that antibiotics, analgesics and other medications may cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock. I have advised my dentist of any and all medications I am taking prior to starting dental work that may have unforeseen negative consequences for me.
Patient Initials _____

2. CHANGES IN TREATMENT PLAN: I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discoverable during previous examinations. For example, root canal therapy may be necessary following routine restorative procedures. I give my permission to my dentist to make any/all changes and additions as necessary.
Patient Initials _____

3. REMOVAL OF TEETH: I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved with extraction, some of which are pain and swelling (Paresthesia) that can last for an indefinite period of time, and fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost for which is my responsibility.
Patient Initials _____

4. CROWNS & BRIDGES: I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crown are delivered. I realize the final opportunity to make changes in my new crowns, bridge, or cap (including shape, fit, and color) will occur only before final cementation. It is also my responsibility to return for permanent cementation within 21 days from the initial tooth preparation. Excessive delays may allow for tooth movement and this may necessitate a remake of the crown or bridge. In such instances, I understand that there will be additional charges for remakes due to my delaying permanent cementation.
Patient Initials _____

5. ENDODONTIC TREATMENT (ROOT CANAL):I realize there is no guarantee that root canal therapy will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling material may extend through the tooth which does not necessarily affect the success of the treatment. I understand that endodontic files are very fine instruments and stresses from the manufacture can cause them to separate during use. I understand that occasionally, additional surgical procedures may be necessary following root canal treatment (apicoetocmy). I understand that the tooth may be lost in spite of all efforts to save it.
Patient Initials _____

7. PERIODONTAL LOSS (TISSUE AND BONE): I understand that **IF**I am being treated for periodontal disease, this means I have a serious condition, causing gum and bone inflammation or loss and that it can ultimately lead to the loss of my teeth. I understand that any dental procedure may have a future adverse effect on my periodontal condition.
Patient Initials _____

8. FILLINGS: I understand that the care must be taken when chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understated that increased sensitivity is a common effect of a newly placed fillings.
Patient Initials _____

9. DENTURES: I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems associated with dentures. Immediate dentures (placement of denture immediately after extractions) may be painful. In addition, immediate dentures often require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delay of 30 days or more, there may be additional charges assessed against me.
Patient Initials _____

I understand that dentistry is an inexact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment(s) which I have requested and authorized.

I here by authorize **Dr. Feras Ziadat** or dental assistants or auxiliaries to proceed with and perform the dental restorations and treatments indicated above and as explained to me. I understand that this is only estimated and subject to modification depending on unforeseen or undiagnosed circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I may be responsible for payment of services rendered.

Name of Patient:_____ **Date:**_____

Signature of Patient or Guardian:_____