DAVIS DENTISTRY

Date: _____

Patient Name: _____
Last First M (preferred name)

Gender M / F **Marital Status**: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Date of Birth: _____ **Social Security #:** _____**E-Mail Address:**_____

Address:_____
Street Apartment #

_____
City State ZIP

Phone #'s: Home _____ Work _____ Ext_____ Cell _____

DENTAL INSURANCE

Primary Insurance
Insurance Co. Name _____
Address: _____
Phone #: _____
Group #: _____ID# _____
Insured's Name: _____
Insured's DOB ____/____/___ SS# _____

Secondary Insurance
Insurance Co. Name: _____
Address: _____
Phone #: _____
Group #: _____ID# _____
Insured's Name: _____
Insured's DOB ___/___/___ SS# _____

Are you currently taking Coumadin (warfarin)? [ ] Yes [ ] No **Are you taking Plavix or aspirin? [ ] Yes [ ] No**

Have you ever had bacterial endocarditis? [ ] Yes [ ] No If Yes, Approximate date(s)_____

WOMEN: Are you pregnant? [ ] Yes [ ] No Nursing? [ ] Yes [ ] No Taking birth control? [ ] Yes [ ] No

Check if you have now, or have had in the past, any of the following: (all must be checked. Even if they are a NO)

Yes/No	Yes/No	Yes/No	Yes/No
[ ] [ ] Abnormal bleeding	[ ] [ ] Chemotherapy	[ ] [ ] Hemophilia	[ ] [ ] Pacemaker
[ ] [ ] AIDS/HIV positive	[ ] [ ] Circulatory problems	[ ] [ ] Herpes	[ ] [ ] Psychiatric care
[ ] [ ] Anaphylaxis	[ ] [ ] Diabetes	[ ] [ ] Hepatitis A, B, or C	[ ] [ ] Radiation treatment
[ ] [ ] Anemia	[ ] [ ] Epilepsy	[ ] [ ] High blood pressure	[ ] [ ] Respiratory disease
[ ] [ ] Angina	[ ] [ ] Fainting	[ ] [ ] Jaw pain	[ ] [ ] Shortness of breath
[ ] [ ] Arthritis	[ ] [ ] Food allergies	[ ] [ ] Kidney disease	[ ] [ ] Stroke
[ ] [ ] Artificial heart valves	[ ] [ ] Headaches	[ ] [ ] Latex allergy	[ ] [ ] Sub Bacterial Endocarditic
[ ] [ ] Artificial joints	[ ] [ ] Head Trauma	[ ] [ ] Liver disease	[ ] [ ] Surgical implant
[ ] [ ] Asthma	[ ] [ ] Heart murmur	[ ] [ ] Material allergies	[ ] [ ] Tobacco use
[ ] [ ] Cancer	[ ] [ ] Heart surgery/Stent	[ ] [ ] Mitral valve prolapse	[ ] [ ] Transplants

List all medications you are currently taking, if any:_____

_____

Have you ever had an adverse reaction to any of the following?
[ ] Antibiotics _____
[ ] Aspirin
[ ] Dental Anesthetics
[ ] (Lidocaine/Novocain)
[ ] Penicillin
[ ] Codeine
[ ] Pain Medications
[ ] Other _____

Consent and Policy

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I authorize the insurance company listed in these forms to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions:

For patients with Insurance:

Benefits for dental treatment vary from plan to plan. Additionally, "Out of Network" benefits are subject to deductibles that vary with each plan. In an effort to provide clear communication with our patients, please be advised as follows;

- **We are a contracted provider** of Guardian Dental, and Cigna "DPPO plan ONLY" (note that if your plan states anywhere on your card "advantage" they may pay less). Any other PPO or Indemnity insurance will be considered "Out of Network" and will require payment in "Full" at the time of service. We will be happy to submit the claims on your behalf for reimbursement.

- The contractual agreement for your dental benefits is between you and the insurance company. **We provide billing as a courtesy**.
- For all insurance carriers that we have a contractual agreement with, we will accept the "In Network" benefits outlined on your individual Explanation of Benefits. You will still be responsible for any or all co-pays, deductibles, or co-insurance amounts due in accordance with the explanation of benefits.
- When insurance benefits have been exhausted and/or terminated, you are responsible for any charges incurred.
- In all cases, you will be responsible for non-covered services that are not covered by your dental plan.
- We are limited to the information that is given to us by your insurance company and cannot be held responsible for percentages or benefits estimated**.**
- **However, it is your responsibility to know your dental plan coverage**.

Payment Agreement:

- **Payment is due when services are rendered.** Accounts may be assessed a late charge of 1 ½% per month, not to exceed 18% annual interest. If any account is sent to collections a collection fee will be added to your account.
- Should your account be placed in collections, you will be responsible for any and all fees and court costs incurred.

I authorize the doctors of Davis Dentistry and office to release all information necessary to secure the payment of benefits. I have read and agree to be financially responsible for all services performed by Dr. Mark Davis and staff.

Printed Name _____

Signature _____ ***Date*** _____

NOTICE OF PRIVACY PRACTICES

Effective Date: February 16, 2026

THIS NOTICE DESCRIBES HOW DENTAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Davis Dentistry- Mark S Davis, DDS, PLLC
31309 N. Scottsdale Rd. Suite 125
Scottsdale, AZ 85266
Ph. 480-595-1300--------www.DavisDentistry.com------Email-mdavisdentistry@gmail.com
Privacy Officer: Priscilla

We are required by the Health Insurance Portability and Accountability Act (HIPAA) to protect your Protected Health Information (PHI).
HOW WE USE AND SHARE YOUR INFORMATION-We may use and disclose your information for the following purposes:

1. Treatment

To provide dental care and related services, such as:

- Examinations, cleanings, X-rays
- Referrals to specialists (e.g., oral surgeons, orthodontists)
- Coordinating care with other healthcare providers

2. Payment

To bill and collect payment from:

- You
- Your insurance company
- A third-party payer
  This may include sharing treatment details with your dental plan.

3. Healthcare Operations

To operate our dental practice, including:

- Quality assessment
- Staff training
- Licensing and compliance activities
- Business management

SPECIAL PROTECTIONS FOR SUBSTANCE USE DISORDER (SUD) INFORMATION

Although dental practices do not typically provide substance use disorder treatment, you may share information related to substance use, medications (such as opioid treatment medications), or related health history.

If our practice maintains records that qualify as substance use disorder treatment records under federal law (42 CFR Part 2):

- We will obtain your written consent before using or disclosing those specific records for most purposes.
- You may revoke your consent in writing at any time, except where we have already relied on it.
- Redisclosure of certain SUD records may be restricted by law.

If this applies to you, we will provide a separate consent form explaining your rights.

YOUR RIGHTS

You have the right to:
Get a Copy of Your Records-Request an electronic or paper copy of your dental records and billing information.
Request a Correction-Ask us to correct information you believe is incorrect or incomplete.
Request Confidential Communications-Ask us to contact you at a specific phone number, address, or method.
Request Restrictions-Ask us not to share certain information for treatment, payment, or operations.
We are required to agree if you pay for a service in full out-of-pocket and request that we not disclose it to your insurance.
Receive an Accounting of Disclosures-Request a list of certain disclosures we have made.
Receive a Paper Copy of This Notice-You may request a paper copy at any time.

OTHER PERMITTED DISCLOSURES

We may also share your information:

When required by law, for public health reporting, for health oversight activities, to prevent a serious threat to health or safety, in response to a court order or legal process

OUR RESPONSIBILITIES

We are required to:

Maintain the privacy and security of your health information, provide you with this Notice, follow the privacy practices described here, notify you if a breach occurs that may have compromised your information

CHANGES TO THIS NOTICE

We may update this Notice from time to time. The revised version will be available: At our front desk, on our website, or upon request

You may also file a complaint with the U.S. Department of Health and Human Services. Filing a complaint will not affect your care.

Davis Dentistry-HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we ***may not be allowed*** to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

Effective February 16, 2026

We care about your privacy. Federal law requires us to protect your dental and health information. Here's what you need to know:

How We Use Your Information

We may use and share your information to:

✔ Provide dental treatment-✔ Bill you or your insurance-✔ Run our practice efficiently and safely-✔ Send appointment reminders (call, text, or email)

Your Rights

You have the right to:

✔ Get a copy of your dental records-✔ Ask us to correct incorrect information-✔ Request confidential communication (different phone/email)-✔ Ask us to limit what we share-✔ Receive a list of certain disclosures-✔ Get a paper copy of our full

Privacy Notice

If you pay out-of-pocket in full for a service, you may request that we not share that information with your insurance company.

Special Protections

If your records include certain sensitive information (such as substance use treatment information, if applicable), we may need your written permission before sharing it.

_____ _____

Please ***print*** name of Patient Please ***sign*** "Patient" / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents:

_____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH/ACCOUNT INFORMATION:

(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS** VIA:

☐ Cell Phone/Text message Confirmation ☐ **Any of the Above**

☐ Home Phone Confirmation

☐ Email/phone Confirmation _____

I AUTHORIZE **INFORMATION ABOUT MY HEALTH, TREATMENT & BILLING INFORMATION** BE CONVEYED VIA:

☐ Cell Phone ☐ **Any of the Above**
☐ Home Phone ☐ Work Phone

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Text Message ☐ **Any of the Above**
☐ Email ☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) _____ _____

Signature of Privacy Officer