PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____
Last First MI (Preferred Name)

Gender: ☐ Male ☐ Female Marital Status: ☐ Child ☐ Single ☐ Married ☐ Other: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Phone (Home): _____ (Cell): _____ E-mail Address: _____

Preferred Form of Contact: ☐ Cell ☐ Home ☐ Email

Emergency Contact: _____ _____ _____
Name *Phone Number* *Relationship to Patient*

How did you hear about Woolf Dental?

☐ Website ☐ Internet ☐ Insurance ☐ Work ☐ Advertisement/Flyer
☐ Patient/Friend: _____ ☐ Other: _____

HEALTH INFORMATION

Date of last dental visit and reason for visit: _____ _____
Approximate Date Reason for Visit

Have you ever had any of the following? Please check those that apply:

ALLERGIES:
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Latex
- ☐ Seasonal

Other: _____
_____
_____

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date: _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other: _____
  _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: _____
_____
_____

Preferred Pharmacy Name/Major Crossroads: _____

- Do you smoke? ☐ Yes ☐ No
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

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

RESPONSIBLE PARTY INFORMATION

The following is the person responsible for payment (if not the patient):

Name:_____ Phone (Cell):_____ Relationship to Patient:_____

If different than patient information:

Address:_____
Street Apartment # City State Zip Code

INSURANCE INFORMATION

Primary

Name of Insured:_____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date:_____ ID #:_____ Group #:_____

Insurance Company Name:_____

Insured's Occupation:_____ Employer Name:_____

If different than patient information:

Insured's Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary

Name of Insured:_____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date:_____ ID #:_____ Group #:_____

Insurance Company Name:_____

Insured's Occupation:_____ Employer Name:_____

If different than patient information:

Insured's Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

CONSENT FOR SERVICES

As a condition of treatment provided by this office, financial arrangements must be made in advance. Our practice relies on timely reimbursement from patients to cover the cost of care. Therefore, financial responsibility must be clearly established prior to treatment.

All emergency dental services, or any services performed without prior financial arrangements, must be paid for in full at the time of service.

Patients with dental insurance understand that all services are charged directly to them, and they are personally responsible for payment. As a courtesy, this office will assist in preparing insurance claims and collecting benefits from insurance companies. Any payments received from insurance will be credited to the patient's account. However, we cannot guarantee payment by any insurance company and do not provide treatment on the assumption that insurance will cover our fees.

A service charge of 1.5% per month (18% annually) will apply to all balances over 60 days past due, unless other written financial arrangements have been made in advance. Fee estimates for proposed dental care are valid for six months from the date of the initial examination.

In consideration of the professional services rendered to me, or at my request, I agree to pay the reasonable value of those services to the doctor or their assignee at the time of service, or within five (5) days of billing if credit is extended. I understand that fees will be considered agreed upon unless I submit a written objection within the time allowed for payment. I also agree that the waiver of any term or condition does not constitute a waiver of future terms or conditions. Should legal action become necessary to collect my account, I agree to pay all costs and reasonable attorney fees incurred.

Missed Appointments: We respectfully request at least 24 hours' notice for any appointment cancellation. Missed appointments without proper notice may be charged at the rate of a standard office visit. Your cooperation helps us provide better care for all patients.

Communication & Information Sharing Consent

I authorize Woolf Dental to contact me by phone, voicemail, text, or email regarding my treatment, scheduling, billing, insurance, and other matters related to my care, using the contact information I have provided. I understand that standard message and data rates may apply and that these communications may not be encrypted or secure. I accept this risk and understand I may opt out at any time by notifying the office in writing.

I also authorize the release of relevant information—including insurance details, treatment plans, notes, x-rays, and lab records—to specialists or healthcare providers involved in my treatment for consultation, referral, or case completion.

I have read and agree to the conditions of treatment and payment outlined above. I acknowledge that I have received and reviewed the Woolf Dental *Notice of Privacy Practices*.

***Acknowledgment and Consent:**_____ **Date:** _____ **Relationship to Patient:**_____
Signature of patient, parent, guardian or guarantor

NOTICE OF PRIVACY PRACTICES

Effective Date: 06/12/2025

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

OUR LEGAL DUTY

We are required by federal and state law to maintain the privacy of your health information ("protected health information" or "PHI"). We must follow the privacy practices described in this Notice while it is in effect. We may change our privacy practices and this Notice at any time, and changes will apply to all PHI we maintain. You may request a current copy of this Notice at any time.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

- **Treatment:** We use and share your PHI to provide, coordinate, or manage your healthcare.
- **Payment:** We use and disclose PHI to bill and receive payment for services.
- **Healthcare Operations:** We use PHI for activities like quality assessment, staff training, and licensing.
- **Authorization:** Uses and disclosures other than treatment, payment, or healthcare operations require your written authorization. You may revoke your authorization at any time in writing, except for disclosures already made.
- **Family and Friends:** We may share PHI with family or others involved in your care if you agree or do not object, or in emergencies or incapacity, based on professional judgment.
- **Required by Law:** We may disclose PHI when required by law, including for public health, law enforcement, or court orders.
- **Abuse and Neglect:** We may report PHI if we suspect abuse, neglect, or domestic violence as allowed or required by law.
- **National Security and Military:** We may disclose PHI to authorized federal officials for national security or to military authorities if applicable.
- **Appointment Reminders and Health Benefits:** We may contact you via phone, voicemail, text, email, or mail with reminders or information about treatment options and health-related benefits. You may request alternative communication methods in writing.

BREACH NOTIFICATION

We will notify you if there is a breach of your unsecured PHI as required by law.

YOUR RIGHTS

- **Access:** You may request to see or get copies of your PHI. We may charge reasonable fees for copying and mailing.
- **Amendment:** You may ask us to correct your PHI; we may deny requests under certain conditions.
- **Accounting of Disclosures:** You may request a list of certain disclosures made in the last six years (first request free, others may have a fee).
- **Restrictions:** You may request limits on uses or disclosures; we are not required to agree except if you pay out of pocket for a service and request we not share it with your insurer.
- **Alternative Communications:** You may request that we communicate with you by alternative means or locations; we will accommodate reasonable requests.
- **Electronic Notice:** If you get this Notice electronically, you can request a paper copy.

TEXT AND EMAIL COMMUNICATION

By providing your phone number or email, you consent to receive health information, appointment reminders, billing notices (including past due balances), and updates via text or email. Standard message and data rates may apply. Email communications are not encrypted. You may opt out at any time by notifying us in writing.

CONTACT INFORMATION & COMPLAINTS

If you have questions, want more information, or wish to file a complaint, contact:

Woolf Dental
Attn: Dallas Woolf, D.D.S
342 N. Val Vista Dr., #104, Mesa, AZ 85213
Phone: (480) 734-2080

You may also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you for filing a complaint.

Office Policies

This document outlines our office policies and procedures to help you understand what to expect during your time at Woolf Dental. Please take a moment to review this form carefully. Thank you for choosing us for your dental needs!

Please check each box showing that you have read and agree to each policy:

- ☐ Payment is due at time of service. All insurance and patient portion quotes given verbally or written are estimated based on information available at the time they are diagnosed and are not guaranteed. Patient is responsible for any fees unpaid by the insurance company.
- ☐ If the insurance company has not fully paid a claim after a reasonable period of time (3 months), the patient will be required to pay the remaining portion.
- ☐ Patient is responsible to inform Woolf Dental of any changes to their dental coverage at least 48 hours before their appointment. (If applicable)
- ☐ Any remaining balance on patient's account must be paid before further treatment is rendered.
- ☐ If under the age of 18, a parent or legal guardian must be present in the waiting room.
- ☐ Patient is responsible for confirming their appointment. Failure to do so may result in appointment being given to someone else that is in need.
- ☐ Arriving late to an appointment may result in needing to be rescheduled. (If you are ever running late, please give us a call).
- ☐ Patient understands that if they fail to give 24 hours notice or "No Show" to a scheduled appointment, they may be charged a fee dependent on the length of their appointment.
- ☐ We ask that only the patient receiving treatment be allowed in the operatory during all visits.

Failure to comply with these policies may result in dismissal from our office. If you have any questions about a specific policy, please do not hesitate to ask.

By signing below I acknowledge that I have read and accept the policies for Woolf Dental.

_____ _____

Signature of patient, parent or guardian Date