Catalina Family Dental
16701 N Oracle Rd #151, Tucson, AZ 85739
(520) 825-4491
catalinafamilydental.com/

NEW PATIENT FORM

Basic Information

Name:		Gender:	
Preferred Name:		DOB:	
SSN #:		Marital status:	
Referral source:		Employer:	
Referred by:		Occupation:	

Contact Information

Mobile phone:	
Home phone:	
Email:	

Address Information

Street address:	
City:	
State:	
ZIP:	

Emergency Contact

Full Name:	
Phone number:	
Relation:	

Work Information

Street address:	
City:	
State:	
ZIP:	

Pharmacy

What is the name and location of your preferred pharmacy?	
Name of Preferred Pharmacy	

Patient's signature: Date:

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NOTICE OF PRIVACY POLICY CONSENT

NOTICE OF PRIVACY PRACTICES

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

OUR LEGAL DUTY

We are required by law to protect the privacy of your protected health information ("medical information"). We are also required to send you this notice about our privacy practices, our legal duties and your rights concerning your medical information.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on the date set forth at the top of this page and will remain in effect unless we replace it. We reserve the right at any time 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 any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change in practices.

We may amend the terms of this notice at any time. If we make a material change to our policy practices, we will provide to you, the revised notice. Any revised notice will be effective for all health information we maintain. The effective date of a revised notice will be noted. A copy of the current notice in effect will be available in our facility and on our website. You may request a copy of the current notice at any time. We collect and maintain oral, written and electronic information to administer our business and to provide products, services and information of importance to our patients. We maintain physical, electronic and procedural safeguards in the handling and maintenance of our patients' medical information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction and misuse.

USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION

Treatment: We may disclose your medical information, without your prior approval, to another dentist or healthcare provider working in our facility or otherwise providing you treatment for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, your health information may be disclosed to an oral surgeon to determine whether surgical intervention is needed.

Payment: We provide dental services. Your medical information may be used to seek payment from your insurance plan or from you. For example, your insurance plan may request and receive information on dates that you received services at our facility in order to allow your employer to verify and process your insurance claim.

Health Care Operations: We may use and disclose your medical information, without your prior approval, for health care operations. Health care operations include:

• healthcare quality assessment and improvement activities;

• reviewing and evaluating dental care provider performance, qualifications and competence, health care training programs, provider accreditation, certification, licensing and credentialing activities;

• conducting or arranging for medical reviews, audits and legal services, including fraud and abuse detection and prevention; and

• business planning, development, management and general administration including customer service, complaint resolutions and billing, de-identifying medical information, and creating limited data sets for health care operations, public health activities and research.

We may disclose your medical information to another dental or medical provider or to your health plan subject to federal privacy protection laws, as long as the provider or plan has had a relationship with you and the medical information is for that provider's or health plan's care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You (or your legal personal representative) may give us written authorization to use your medical information or to disclose it to anyone for any purpose. Once you give us authorization to release your medical information, we cannot guarantee that the person to whom the information is provided will not disclose that information. You may take back or "revoke" your written authorization at any time, except if we have already acted based on your authorization. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We will obtain your authorization prior to using your medical information for marketing, fundraising purposes or for commercial use. Once authorize, you may opt out of these communications at any time.

Family, Friends and Others involved in your care or payment for care: We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose on the medical information that is relevant to the person's involvement.

We may use or disclose your name, location and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits, services, payment for those products and services and treatment alternatives.

Reminders: We may use or disclose medical information to send you reminders about your dental care, such as appointment reminders via US Mail, email, text message, and telephone. By providing your email address to us, you agree that you may receive reminders and breach notifications via email as a possible alternative to US Mail. It is the policy of our office to leave a message on any voicemail or answering machine that may be attached to a number that you provide (home, cell or work). If you prefer that we NOT leave a message to confirm treatment or your appointments, please indicate that on the communication consents form.

Plan Sponsors: If your dental insurance coverage is through an employer's sponsored group dental plan, we may share summary health information with the plan sponsor.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law and when authorized by law for the following kinds of public health and public benefit activities;

• for public health, including to report disease and vital statistics, child abuse, adult abuse, neglect or domestic violence;

• to avert a serious an imminent threat to health or safety;

• for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities and fraud prevention agencies;

• for research;

• in response to court and administrative orders and other lawful process;

• to law enforcement officials with regard to crime victims and criminal activities;

• to coroners, medical examiners, funeral directors and organ procurement organizations;

• to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and

• as authorized by state worker's compensation laws.

Special protections for SUD records: Substance Use Disorder (SUD) Treatment records have enhanced protections. They cannot be used in legal proceedings without your consent or court order.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Business Associates: We may disclose your medical information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes: We may use your contact information to provide legally required notices of unauthorized acquisition, access or disclosure of your health information.

Additional Restrictions on use and disclosure: Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly Confidential Information" may include confidential information under Federal laws governing reproductive rights, alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

1) HIV/AIDS;

2) Mental Health;

3) Genetic Tests (in accordance with GINA 2009);

4) Alcohol and drug abuse;

5) Sexually transmitted diseases and reproductive health information; and

6) Child or adult abuse or neglect, including sexual assault.

YOUR RIGHTS

1) You have a right to see and get a copy of your health records.

2) You have a right to amend your health information.

3) You have a right to ask to get an Accounting of Disclosures of when and why your health information was shared for certain purposes.

4) You are entitled to receive a Notice of Privacy Practices that tells you how your health information may be used and shared.

5) You may decide if you want to give your Authorization before your health information may be used or shared for certain purposes, such as marketing. It is the policy of our office NOT to sell or disclose your information to any outside firms or business partners. Your information may be used, only within our office, for the purposes of presenting to you certain products or services which our dentist(s) or staff feel may present a benefit for you, your oral health or happiness with your smile.

6) You have the right to receive your information in a confidential manner and restrict certain communication methods.

7) You have a right to restrict who receives your information.

8) You have a right to request amendment to be made to your health records by submitting the request in writing to our office. Your request does not guarantee the amendment, but does guarantee that it will be reviewed and

considered.

9) If you believe your rights are being denied or your health information is not being protected, you can:

a. File a complaint with your provider, health insurer, or with the Office for Civil Rights of the United States Department of Health and Human Service.

We will not retaliate against you if you file a complaint.

We reserve the right to change the terms of this notice. This notice was published and became effective January 19, 2026

I acknowledge that I have received a copy of this office’s Notice of Privacy Practices.

Patient's signature: Date:

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FINANCIAL POLICY

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

INSURANCE:

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

PAYMENT:

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made.

UNPAID BALANCES after 90 days will be sent to a collection agency. If payment is delinquent, the patient will be responsible for payment of collection, attorney’s fees, and court costs associated with the recovery of the monies due on the account.

MISSED APPOINTMENTS:

To ensure that each patient is given the proper amount of time allotted for their visit and to enable us to provide the highest quality care to everyone, it is very important for each scheduled patient to attend their visit on time. As a courtesy, we will attempt to provide an appointment reminder to you within 10 days of your scheduled appointment. However, it is your responsibility to arrive for your appointment on time, even if you do not receive a reminder. Please remember to confirm via text, email, or phone.

Any unconfirmed appointments 24 hours in advance of the scheduled visit may be removed from our schedule. We require that our patients give us a minimum of 24 hour notice if they cannot keep their reserved appointment time. There will be a $50.00 cancellation fee that will be charged for missed appointments and/or appointments cancelled less than 24 hours in advance. Please help us maintain the highest quality of care by keeping scheduled appointments.

I have read, understand and agree to the terms and conditions of this Financial Agreement.

Patient's signature: Date:

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COMMUNICATION CONSENTS

VOICEMAIL, ANSWERING MACHINE, EMAIL CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you on communication devices or via email regarding your Protected Health Information. Catalina Family Dental offers patients the opportunity to communicate by email. Transmitting patient information by voicemail or email has a number of risks that patients should consider before granting consent to use email for these purposes. Catalina Family Dental will use reasonable means to protect the security and confidentiality of email information sent and received. However, Catalina Family Dental cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information. I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of voicemail or email between Catalina Family Dental and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Catalina Family Dental.

Patient's signature: Date:

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TEXT MESSAGE TO MOBILE CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by mobile text messaging regarding your Protected Health Information. Catalina Family Dental, offers patients the opportunity to communicate by mobile text messaging. Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use mobile text messaging for these purposes. Catalina Family Dental will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. Your phone number will not be shared. However, Catalina Family Dental cannot guarantee the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information. Message frequency may vary. Message and data rates may apply. I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of mobile text messaging between Catalina Family Dental and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Catalina Family Dental.

Patient's signature: Date:

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HEALTH HISTORY
I DOB:

Summary

Medical Conditions	
Allergies	
Medications	

General Health Information

Are you currently under the care of a physician?	
Physician phone number	
Date of last physical exam	
What is the name of your pharmacy?	
Are you presently being treated for any injury or illness?	
Have you ever been hospitalized for an injury or illness?	
Are you pregnant or planning to become pregnant?	
Are you currently breastfeeding?	
Are you required to pre-med with antibiotics before dental treatment?	
Do you use alcohol?	
Do you use or have you ever used tobacco?	
Have you ever had an allergic reaction?	

Medical Conditions

Please check all conditions that you have history of or are currently being treated for	
Do you have a history or are currently being treated for any Digestive conditions?	
Do you have a history or are currently being treated for any Heart or Circulatory conditions?	
Do you have a history or are currently being treated for any Neurological conditions?	
Do you have a history or are currently being treated for any Lung or Breathing conditions?	
Do you have a history or are currently being treated for any Autoimmune conditions?	
Head or neck injuries?	
Artificial Joint?	
High cholesterol?	
History of cancer?	
Tumor or abnormal growth?	
Radiation therapy?	
Chemotherapy?	

HIV / AIDS?	
Osteoporosis / osteopenia?	
Type I or Type II diabetes?	
Anemia?	
Kidney disease?	
Liver disease?	
Thyroid disease?	
Tuberculosis / measles / chicken pox?	
Any other medical condition we should know of?	

Medications

Please check all medications you are currently taking	
Are you taking any pain medications?	
Are you taking any Antidepressants or Anxiety medications?	
Are you taking any Diabetes, Cholesterol, or Blood Pressure medications?	
Are you taking any Blood Thinners?	
Are you taking any Bisphosphonates or Medications for Osteoporosis?	
Are you currently taking any other medications or dietary supplements?	

Patient's signature: Date:

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DENTAL HISTORY

I DOB:

General Information

Who was your previous Dentist and how long were you a patient there?	
Date of your last dental exam	
Date of your last cleaning	
Have you ever had a deep cleaning or had to be numbed for cleanings?	
Do you have any immediate concerns you'd like us to address?	

Office Relationship

What do you value most in your dental visits?	
On a scale from 1-5, 5 being most terrified, are you fearful of dental treatment?	

Personal History

Please answer the following questions	
Have you had any cavities within the past 2 years?	
Are any teeth currently sensitive to biting, sweets, hot, or cold?	
Do you wear, or have you ever worn a bite appliance? Either for clenching at night (a night guard) or for sleep apnea?	
Does the amount of saliva in your mouth seem too little or do you find yourself with a dry mouth often?	

Dental Structural History

Please answer the following questions	
Do your gums bleed when brushing or flossing?	
Have you ever been treated for or been told you have gum disease?	
Have you had any teeth removed for braces or otherwise?	
Do you know of any missing teeth or teeth that have never developed?	
Do you frequently get food caught between any teeth?	
Do you have problems with your jaw joint? (TMD, popping, clicking, deviating from side to side when opening or closing?)	

Patient's signature: Date:

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HIPAA – RELEASE OF INFORMATION AUTHORIZATION FORM

I DOB:

HIPAA - RELEASE OF INFORMATION AUTHORIZATION FORM

In compliance with federal and state law, the release of information for any person 18 years or older (including the information regarding a spouse or adult child), **must first be authorized**. Authorization includes the signature of the individual authorizing the release of their information. Information **will not be available** to anyone other than the covered patient (i.e. a member, a spouse, or any dependent age 18 or older) without first having this Release of Information Authorization on file. For example, if a subscriber calls about the status for a claim on a 19-year old dependent, that information will not be given to the subscriber without the written consent of the dependent. The same situation holds true for spouse-to-spouse information. However, parents do have a right to information on children under the age of 18 without the child's consent.

I want to provide the authorization	

Information Regarding Person Authorizing Releasing His/Her Information

Name of person authorizing release	
Date of Birth person authorizing release	
Personal Information to be released	
The above information may be released and/or received by	

The following is an authorization allowing Catalina Family Dental to release information to whomever you designate. Catalina Family Dental is authorized to make the disclosure of my benefits information, claim(s) status, claim(s) history, general claim information, dentist information, lab cases, and enrollment information, unless otherwise specified to the following individual(s) or organization(s):

Name of person/organization that the office may release my information to	
Relation of person/organization that the office may release information to	
Phone number of person/organization that the office may release information to	
I want to add a second person/organization	
Name of person/organization that the office may release my information to	
Relation of person/organization that the office may release information to	
Phone number of person/organization that the office may release information to	
I want to add a third person/organization	
Name of person/organization that the office may release my information to	
Relation of person/organization that the office may release information to	
Phone number of person/organization that the office may release information to	
I want this consent to	

AUTHORIZATION CONSENT

I understand that consent may be revoked by me at any time in writing. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in the practice's Notice of Privacy Practices.

Patient's signature: Date:

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RELEASE OF RECORDS AUTHORIZATION

I DOB:

Please select which scenario applies to you	
What is your previous dentist's name/practice name?	
What is your previous dentist's address?	
What is your previous dentist's phone number?	
What is your previous dentist's email address?	

RELEASE OF RECORDS AUTHORIZATION

By signing below, I consent for my dental treatment records and x-rays to be transferred by email to support@catalinafamilydental.com.

Practice Name: Catalina Family Dental

Practice Address: 16701 N Oracle Rd #151, Tucson, AZ 85739

Practice Phone number: (520) 825-4491

Patient's signature: Date: