9481 E. Ironwood Square Drive, Scottsdale, AZ 85258 Ph.: 480-945-3629 Fax: 480-664-8972 www.aztmj.com

Patient Information and Health Questionnaire

☐ MR. ☐ MS. ☐MISS ☐ MRS. ☐ DR. **TODAY'S DATE:** _____

PATIENT NAME: _____
First Middle Initial Last

AGE: _____ **DATE OF BIRTH:** _____ ☐ **MALE** ☐ **FEMALE**

ADDRESS: _____ **CITY/STATE/ZIP**: _____

CELL PHONE: _____ **HOME PHONE:** _____

WORK PHONE: _____ **EMAIL:** _____

SS#: _____ **MARITAL STATUS:** ☐ SINGLE ☐ MARRIED

DRIVERS LICENSE #/STATE_____ ☐ **Copy of Drivers License***
*In accordance with the Federal Trade Commission's Red Flag regulations to protect your medical record and identity

EMERGENCY CONTACT PERSON (NAME AND PHONE #): _____

REFERRED BY: _____ ☐ DDS ☐ MD ☐ENT ☐ DC ☐ OTHER

REASON FOR THIS APPOINTMENT:
☐ **FACE PAIN** ☐ **JAW PAIN** ☐ **HEADACHES** ☐ **FATIGUE/BREATHING CONCERNS** ☐ **OTHER:** _____

EMPLOYER NAME: _____ **PHONE:** _____

ADDRESS: _____ CITY/STATE/ZIP: _____

JOB TITLE: _____

PAYMENT TYPE: ☐ **INSURANCE** ☐ **SELF-PAY** ☐ **AUTO** ☐ **WORKERS COMP.**

HEALTH INSURANCE NAME: _____ **ID#/ GROUP#**:_____
☐ **Copy of health insurance card*** Member Services Phone# (on card) _____
*In accordance with the Federal Trade Commission's Red Flag regulations to protect your medical record and identity

PRIMARY INSURED NAME/DATE OF BIRTH: _____
RELATIONSHIP TO PRIMARY INSURED: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER:_____

WORKERS COMP.: INSURANCE NAME: _____

CASE MANAGER NAME AND CONTACT #: _____

CLAIM #: _____ **DATE OF INJURY:** _____

AUTO: DATE OF ACCIDENT: _____

ATTORNEY AND/OR AUTO INSURANCE NAME: _____

ADDRESS: _____

PHONE #: _____ **POLICY #:** _____

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WHAT ARE YOUR 3 CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?
Please mark only 3 main complaints then rate your complaints for **intensity** on a scale of 0-10 with 0 being none and 10 being the worst.

- □ Jaw Pain ____
- □ Headache Pain ____
- □ Facial Pain ____
- □ Throat Pain ____
- □ Tooth grinding ____
- □ Jaw Joint Locking ____
- □ Dizziness ____
- □ Kicking and jerking leg repeatedly ____
- □ Fatigue ____
- □ Repeated-awakening ____
- □ Significant daytime drowsiness ____
- □ Told that "I stop breathing" during sleep ____
- □ Ear Pain ____
- □ Pain when chewing ____
- □ Eye Pain ____
- □ Neck Pain ____
- □ Limited ability to open mouth ____
- □ Jaw Joint Noises ____
- □ Tinnitus (ringing in the ears) ____
- □ Dry Mouth when waking ____
- □ Difficulty falling asleep ____
- □ Feeling unrefreshed in the morning ____
- □ Frequent heavy snoring ____
- □ Unable to tolerate C-Pap ____

MEDICAL HISTORY

TELL US YOUR MEDICAL STORY: _____

_____

When did your condition first occur? _____

What do you believe is the cause of your pain or condition?

Pick One:

☐AUTO ACCIDENT ☐MOTORCYCLE ACCIDENT ☐WORK RELATED ACCIDENT

☐ATHLETIC ENDEAVOR ☐FIGHT ☐FALL ☐ACCIDENT ☐ILLNESS ☐INJURY

☐UNKNOWN ☐OTHER:_____

Is there anything that makes your pain or discomfort worse? _____
(Please describe)

Is there anything that makes your pain and discomfort better? _____
(Please describe)

What other information is important to your pain or condition? _____
(Please describe)

ALLERGIC REACTIONS

Please list all medications and check or list the substances that have caused an ALLERGIC REACTION

☐ANESTHETICS ☐IODINE ☐LATEX ☐METALS ☐Other: _____

☐Other: _____ ☐Other: _____ ☐Other: _____

CURRENT MEDICATIONS ☐ Patient medication list attached

Please list all medications you are taking and the reason you take them. Include all over-the-counter medications, vitamins, herbs, etc.

Medication	Dosage	Reason for taking

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PREVIOUS TREATMENTS/MEDICATIONS FOR THE CONDITION WE ARE EVALUATING

Treatment and/or Medication	Doctor/Provider Name	Approximate Date of Treatment

_____

_____

_____

_____

_____

_____

HEALTH AND MEDICAL HISTORY

Have you ever had prior orthodontic treatments? ☐YES ☐NO

Are you currently pregnant? ☐YES ☐NO

Are you currently breastfeeding? ☐YES ☐NO

SURGICAL HISTORY

Have you had your wisdom teeth removed? ☐YES ☐NO

Have you ever had a root canal or any other tooth removal for this condition? ☐YES ☐NO

Have you ever had Jaw Joint Surgery? ☐YES ☐NO

Have you ever had Orthognathic Surgery? ☐YES ☐NO

Any other types of surgery? _____

_____

MEDICAL HISTORY

Please check all that apply and leave all others blank, if there is anything not listed please indicate the information in the OTHER section.

Allergy History
- □ Allergy Skin Testing
- □ Allergen Desensitization
- □ Hay Fever

Eye History
- □ Cataract
- □ Visual Impairment
- □ Glaucoma

Cardiac History
- □ Congestive Heart Failure
- □ Heart Attack
- □ Rhythm Disorder
- □ Functional Murmur
- □ Mitral Valve Prolaspe
- □ Angina Pectoris
- □ Prior MI
- □ Coronary Artery Disease
- □ Peripheral Vascular
- □ Hypertension

ENT History
- □ Adenoidectomy
- □ Tonsillectomy
- □ Turbinectomy

Pulmonary History
- □ Asthma
- □ COPD
- □ Bronchitis

Gastrointestinal History
- □ Hepatitis
- □ Acute Colitis
- □ Irritable Bowel Syndrome
- □ Esophageal Reflux
- □ Esophageal Ulcer
- □ Peptic Ulcer
- □ Chronic Reflux Esphagitis
- □ Esophagitis
- □ Esophageal Stricture
- □ Hiatal Hernia

Cancer History
- □ Cancer
- □ Chemotherapy
- □ Radiation Therapy

Infectious Disease
- □ Measles
- □ Chicken Pox
- □ Smallpox
- □ Diphtheria

Trauma
- □ Facial Injury
- □ Head Injury
- □ Neck Injury
- □ Mouth Injury

Hematological History
- □ Anemia
- □ Bleeding/Clotting
- □ Leukemia
- □ HIV

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MEDICAL HISTORY Cont.

Please check all that apply and leave all others blank, if there is anything not listed please indicate the information in the OTHER section.

Kidney/Bladder History
- □ Prostate Disorders
- □ Renal Failure
- □ Stress Incontinence
- □ Urinary, Bladder Infections
- □ Kidney Stones
- □ Urinary Calculus

Endocrine History
- □ Diabetes Mellitus
- □ Thyroid Disorders
- □ Chronic Fatigue

Neurological History
- □ Epilepsy
- □ TIA
- □ Stroke Syndrome
- □ Multiple Sclerosis
- □ Depression
- □ Bipolar Disorder
- □ ADHD
- □ Migraine Headaches
- □ Vascular Headaches

Musculoskeletal History
- □ Osteoarthritis
- □ Arthritis
- □ Rheumatoid Arthritis
- □ Osteoporosis
- □ Fibromyalgia

OTHER HISTORY ITEMS NOT LISTED: _____

CURRENT SYMPTOMS

Systemic symptoms
- □ Feeling tired or poorly
- □ Weight change
- □ Chills
- □ Fever

Otolaryngial Symptoms
- □ Mouth sores
- □ Difficulty swallowing (dysphagia)
- □ Difficulty chewing
- □ Dentures currently being worn
- □ Dentures improperly fitting

Head symptoms
- □ Headache
- □ Facial pain
- □ Sinus pain
- □ Tooth pain

Musculoskeletal symptom
- □ Joint pain, localized in the jaw (joint)
- □ Diffuse joint pains (arthralgias)
- □ Joint pain, localized
- □ Joint swelling, localized
- □ Muscle aches
- □ Muscle cramps
- □ Legs feel restless
- □ Other

Neck symptoms
- □ Neck pain
- □ Neck stiffness
- □ Lump or swelling

Gastrointestinal
- □ Appetite
- □ Heartburn
- □ Nausea
- □ Vomiting
- □ Abdominal pain
- □ Regurgitation
- □ Yellow skin/eyes (jaundice)
- □ Inability to pass gas
- □ Bowel movement frequency
- □ Diarrhea
- □ Unable to control passing gas
- □ Constipation
- □ Rectal Pain

Neurological symptoms
- □ Dizziness
- □ Vertigo
- □ Fainting (syncope)
- □ Motor disturbances
- □ Sensory disturbances
- □ Decreased concentrating ability

Cardiovascular
- □ Chest pain or discomfort
- □ Palpitations
- □ Slow heart rate
- □ Leg pain with exercise
- □ Cold hands/feet

Endocrine
- □ Temperature intolerance
- □ Excessive sweating
- □ Hot flashes
- □ Muscle weakness
- □ Muscle weakness
- □ Sexual complaints
- □ Changes in body proportion
- □ Hair symptoms

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CURRENT SYMPTOMS Cont. Please check all that apply and leave all others blank

Psychological symptoms
- ☐ Mood
- ☐ Energy level
- ☐ Behavior
- ☐ Sleep disturbances
- ☐ Neurological symptoms

Skin symptoms
- ☐ Pruritus
- ☐ Skin Lesions
- ☐ Rashes

OTHER SYMPTOMS NOT LISTED: _____

HEAD PAIN

If you have different levels of headaches, the below refers to the worst headache as opposed to a daily tension-type headache.
Location L=Left R=Right B=Both

☐L ☐R ☐B Frontal (Forehead) ☐Recent ☐Chronic (over 5 months)
Severity ☐Mild ☐Moderate ☐Severe
Duration ☐Min. ☐Hrs. ☐Days
Frequency ☐Occasional ☐Frequent ☐Constant

☐L ☐R ☐B Generalized ☐Recent ☐Chronic (over 5 months)
Severity ☐Mild ☐Moderate ☐Severe
Duration ☐Min. ☐Hrs. ☐Days
Frequency ☐Occasional ☐Frequent ☐Constant

☐L ☐R ☐B Parietal (Top of head) ☐Recent ☐Chronic (over 5 months)
Severity ☐Mild ☐Moderate ☐Severe
Duration ☐Min. ☐Hrs. ☐Days
Frequency ☐Occasional ☐Frequent ☐Constant

☐L ☐R ☐B Occipital (Back of Head) ☐Recent ☐Chronic (over 5 months)
Severity ☐Mild ☐Moderate ☐Severe
Duration ☐Min. ☐Hrs. ☐Days
Frequency ☐Occasional ☐Frequent ☐Constant

☐L ☐R ☐B Temporal (Temple Area) ☐Recent ☐Chronic (over 5 months)
Severity ☐Mild ☐Moderate ☐Severe
Duration ☐Min. ☐Hrs. ☐Days
Frequency ☐Occasional ☐Frequent ☐Constant

Please check the appropriate boxes, if applicable.

JAW PAIN
L☐ R☐ Jaw Pain when opening
L☐ R☐ Jaw Pain when chewing
L☐ R☐Jaw Pain at rest

JAW JOINT SOUNDS (Clicking, Crunching, Popping)
L☐ R☐ Jaw Sounds when opening
L☐ R☐ Jaw Sounds when chewing
L☐ R☐ Jaw Sounds at rest

JAW LOCKING
Yes☐ No☐ Jaw Locks Closed
Yes☐ No☐ Jaw Locks Open

JAW JOINT SYMPTOMS
Yes☐ No☐ Teeth Clenching Day☐ Night☐
Yes☐ No☐ Teeth Grinding Day☐ Night☐

EYE RELATED CONDITIONS
Yes☐ No☐ Blurred Vision
Yes☐ No☐ Double Vision
Yes☐ No☐ Eye Pain

Yes☐ No☐ Pain or pressure behind the eyes
Yes☐ No☐ Extreme Sensitivity to light
Yes☐ No☐ Wear Glasses or Contacts

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EAR RELATED CONDITIONS

L☐ R☐ Buzzing in the ears
L☐ R☐ Ear congestion
L☐ R☐ Ear pain
L☐ R☐ Hearing Loss
L☐ R☐ Itching or stuffiness in the ears
L☐ R☐ Pain behind the ear
L☐ R☐ Pain in front of the ear
L☐ R☐ Recurrent ear infections
L☐ R☐ Ringing in the ear (Tinnitus)

MOUTH AND NOSE RELATED CONDITIONS

Yes☐ No☐ Dry Mouth
Yes☐ No☐ Chronic sinusitis
Yes☐ No☐ Frequent snoring
Yes☐ No☐ Burning tongue
Yes☐ No☐ Broken teeth
Yes☐ No☐ Frequent biting of the cheek

SLEEP CONDITIONS

Please select yes or no answers on your average sleep experience and/or what a sleep partner has told you

Sleep Positions Side☐ Back☐ Stomach☐ Varies☐
Is it easy to fall asleep? Yes☐ No☐
Do you feel rested upon AM waking? Yes☐ No☐
Stopped breathing during sleep? Yes☐ No☐
Average hours of sleep per night _____
Do you wake often during the night? Yes☐ No☐
Gasping or Choking during sleep? Yes☐ No☐
Have you ever had a Sleep Study (PSG)? Yes☐ No☐
Result was:_____

Family History

☐ Diabetes Mellitus
☐ Cancer
☐ Loss of Hearing
☐ Allergies
☐ Stroke
☐ Hypertension
☐ Asthma
☐ Heart Disease
☐ CAD – Coronary artery disease
☐ CHF – congestive heart failure
☐ Pulmonary Hypertension
☐ PVD – peripheral vascular disease
☐ Migraine Headache
☐ Cluster Headache
☐ Meniere's Disease
☐ Neurofibromatosis Type 1 (Recklinghausen's Disease)

Social History

☐ Life circumstance event
☐ Caffeine use
☐ Tobacco use
☐ Smoking cigarettes
☐ Alcohol
☐ Drug use
☐ Marijuana use
☐ Occupation _____

By signing below, I authorize the release of all examination findings and diagnosis, report and treatment plans, etc. to any referring or treating health care provider. I additionally authorize the release of any medical information to insurance companies, or for legal documentation to process claims. I understand that I am responsible for all chargers incurred for my treatment regardless of insurance coverage.

Patient/Guardian Signature _____ **Date:** _____

Printed Patient Name_____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations?

Check one in each row:	0 No chance of dozing	1 Slight chance of dozing	2 Moderate chance of dozing	3 High chance of dozing
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in a public place (ex. a theater or a meeting)	☐	☐	☐	☐
As a passenger in a car For an hour without a break	☐	☐	☐	☐
Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
Sitting and talking to Someone	☐	☐	☐	☐
Sitting quietly after a lunch without alcohol	☐	☐	☐	☐
In a car, while stopped for a few minutes in traffic	☐	☐	☐	☐

Total Score: _____

Patient name: _____ Date: _____

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HEALTH CARE PRACTITIONERS AND PATIENT COMMUNICATION

Please provide us with the names and addresses of all of your doctors and health care providers.

FAMILY DENTIST

PROVIDER NAME: _____

CITY/STATE:_____

□ORTHODONTIST □ORAL SURGEON □ENDODONTIST

PROVIDER NAME: _____

CITY/STATE:_____

FAMILY PHYSICIAN

PROVIDER NAME: _____

CITY/STATE:_____

SPECIALTY PROVIDERS

SPECIALTY: _____

PROVIDER NAME: _____

CITY/STATE:_____

SPECIALTY: _____

PROVIDER NAME: _____

CITY/STATE:_____

SPECIALTY: _____

PROVIDER NAME: _____

CITY/STATE:_____

By signing below, I am giving my permission to communicate with the above named health care providers regarding my treatment.

Patient/Guardian Signature _____ **Date:** _____

Printed Patient Name_____

CONSENT FORM FOR CARE

I, _____ agree to be evaluated and treated at AZTMJ, PLLC, (herein after referred to as The Practice) by Dr. Stan Farrell as deemed medically appropriate. I acknowledge that no procedure will be performed without having been provided appropriate information regarding treatment and possible side effects or consequences. Signing this document implies informed consent on the part of the patient. In this arena, the Practice is released from harm. Although the physician and staff will make efforts to obtain my appropriate medical history and information, the Practice shall not be held responsible for issues of omission or negligence on the part of the patient.

I further acknowledge that the Practice is not functioning as my primary care/family physician, and if there are issues dealing with my primary care or internal medicine, they may be referred to my primary care physician by the Practice. There may also be instances where the Physician of the Practice will refer me to additional specialty care and evaluation as needed.

As for my responsibility to the Practice, I agree to attend appointments and therapies as scheduled. Multiple missed appointments, or inappropriate behavior may result in termination of services and referral to their physicians. Failure to cancel or no show for appointments will be subject to a charge for that visit.

During your therapy, it may become necessary to discuss surgical treatment options if painful or restrictive joint function continues. This may include arthroscopic or open TMJ surgery and/or possible jaw repositioning surgery. Dr. Farrell will, if necessary, discuss these options thoroughly. Following initial appliance therapy, there may be decisions to make by the patient and doctor concerning stabilizing or correcting the bite at the natural jaw position, determined by your muscles, if necessary. As joints and muscles relax and heal, there will be changes in your bite (how your teeth come together). Once, it is felt that you have reached your optimum level of improvement, adjusting your bite to your new jaw position may be recommended.

As part of your care, you may receive injections of one kind or another. Usually, these are trigger point injections into the motor point of various painful muscles. On occasion, a joint injection or Synvisc/Hyalgan injection will be done. This consent for treatment acknowledges that there can be side effects from any injection. Side effects can include: allergic reactions, localized pain at the injection site or pain along the referral pattern of the nerve or muscle injected. On rare occasions more serious adverse events have been known to occur: fever, infection, muscle and bone atrophy, rash anaphylaxis, pneumothorax, breathing difficulty, sudden changes in blood pressure, convulsions, death.

If a procedure is going to be done, a further discussion will ensue, but you are encouraged to ask questions. We wish to empower you to seek a higher level of health by getting involved. Help us to understand you.

Headache, TMJ Disorders, and Sleep Apnea are chronic conditions that are managed, not cured. We are not able to guarantee that all patient's conditions will improve. Upon rare occasion, conditions and symptoms may worsen.

No Intra-Oral Exam Performed We will not be examining your teeth or oral cavity, even though we will be looking in your mouth for other issues. Additionally, we will not be taking x-rays of your teeth. It is your responsibility to have a general dentist examine and maintain you oral health. If you do not have a general dentist we would be happy to recommend one.

Imaging (CT MRI) It may be required to have imaging of the head and neck performed for diagnostic and treatment purposes. Ultrasound and ICAT units are available on premises or a referral to an imaging center will be made.

Stark Policy/Notice Dr. Farrell may at times refer patients to Lab Express for lab work or to AZPMR for evaluation & treatment: both facilities are owned and operated by family members. Dr. Farrell does not have ownership, any financial interests nor does he receive any monetary compensation from either of the above entities.

Drug and Urine Screening At random times at the doctor's discretion our patients may be asked to provide a specimen for screening. This is intended to understand what chemical factors are contributing to your symptoms. An inquiry to the State Pharmacy Board may also be performed when indicated.

Patient/Guardian Signature_____**Date** _____

Printed Patient Name _____

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Financial Policy

Insurance Patients

Please be informed that your Insurance Company does not pay for everything and we cannot guarantee what services or items will be covered by your insurance. If your Insurance Company doesn't pay for the services, or or items provided, you will be responsible for payment in full. It is your responsibility to check on your in-network and out-of-network benefits which can vary widely amongst insurance plans. If you have not met your deductible, it may be collected at the time of service.

If we are out-of-network with you Insurance Company, you will be responsible to bring us all correspondence from the Insurance Company and sign over any insurance checks sent directly to you or make payment directly to AZTMJ.

Non-Insurance Patients

All payments are to be made at the time of service. We accept cash, check, and credit cards and also offer the option of financing your treatment. If you wish to bill an insurance company during any time during or after treatment for reimbursement we can provide you with the necessary forms upon request.

All Patients

A $75 fee is charged for missed appointments without a 24 hour advanced notice. A $35 fee will be charged for any checks returned for insufficient funds.

Any amounts that are 90 days past due may go to collections, and you agree to be responsible for legal fees (court, attorney, process server), collection agency fees, interest charges (2% per month) and any other expenses incurred in the collection of your debt.

If appliance therapy is utilized, we will require a $500.00 deposit towards the fabrication of the appliance(s).

If treatment is rendered on a minor child, the parent or guardian who accompanies the child to the appointment is financially responsible for the amount due.

I understand that all fees paid are for services rendered. **Fees are non-refundable and are not based on results of treatment**.

By signing below, you understand and agree to the terms of this financial policy.

Patient/Guardian Signature _____**Date:** _____

Printed Patient Name_____

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Notice of Privacy Practices

To our patients: This notice describes how health information about you as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your Health Information in Special Circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by appropriate authorities.
6. To federal officials for the intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement official.
8. For workers compensation and similar programs.

Your rights regarding your health information

1. Communication. You can request that our practice communicate with your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical and billing records, but not including psychotherapy notes. You must submit your request in writing to: AZTMJ Medical Records Dept. 9481 E. Ironwood Square Drive, Scottsdale, AZ 85258.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to: AZTMJ, Attn: Office Manager, 9481 E. Ironwood Square Drive, Scottsdale, AZ 85258. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact any front office receptionist at AZTMJ, 9481 E. Ironwood Square Drive, Scottsdale, AZ 85258 or call (480)945-3629.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice contact: AZTMJ, Attn: Office Manager, 9481 E. Ironwood Square Drive, Scottsdale, AZ 85258. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact:
AZTMJ, Attn: Office Manager, 9481 E. Ironwood Square Drive, Scottsdale, AZ 85258 or call (480) 945-3629 for further information.

I hereby acknowledge that I have been presented with a copy of AZTMJ Notice of Privacy Practice.

Patient/Guardian Signature _____Date: _____

Printed Patient Name_____

Print