- ## Patient Information

Name:_____Preferred Name: _____

Home Address:_____City:_____State_____Zip: _____

Home #:_____Work #:_____Mobile #: _____

Email: _____

Sex: M / F Birth Date:____/____/_____ SS#:_____

Family Status (circle): Single | Married | Divorced | Child Spouse's Name: _____

How did you first hear about our office? (Circle one):

Another Patient	Another Dental Office	Brochure	Online Search
Facebook	Work	School	Insurance Website
Sign –Drive by	Walk in	Other: _____	

Whom may we thank for referring you to our practice?_____

- ## Person Responsible for Account (If different from above)

Name of responsible party: _____

Relationship to patient (Circle): Self | Spouse | Parent | Other: _____

Home Address:_____City:_____State:_____Zip: _____

Home #:_____Work #:_____Mobile #: _____ Email: _____

Birth Date: ___/____/_____ SS#: _____

- ## Emergency Contact

Name_____Contact Number _____ Relationship to patient: (circle one) Spouse | Family | Other

INSURANCE INFORMATION (PRIMARY)

INSURED'S NAME:
INSURED'S EMPLOYER:
INSURED'S DOB: ____/_____/_____
INSURANCE COMPANY:

ID# _____ Group#_____

Insurance Phone Number: _____

Claim Address: _____

_____

Payor ID: _____

INSURANCE INFORMATION (SECONDARY)

INSURED'S NAME:
INSURED'S EMPLOYER:
INSURED'S DOB: ____/_____/_____
INSURANCE COMPANY:

ID# _____ Group#_____

Insurance Phone Number: _____

Claim Address: _____

_____

Payor ID: _____

- ## Medical History

Patient Name:_____Date of Birth: _____

1 Date of last physical exam:_____Physician's Name:_____Physician's Phone#: _____

2 Have you ever been hospitalized? Yes No

3 Have you ever had any excessive bleeding requiring special treatment? Yes No

4 **Women:** Are you pregnant/trying to get pregnant/breast feeding? Yes No

5 **Are you allergic to or have you had an allergic reaction to any of the following (please circle if yes):**

Local Anesthetic	Penicillin	Codeine	Other Antibiotic: _____
Latex	Acrylic	Metals	Other:_____

6 **Are you taking or have you ever taken BISPHOSPHONATE, or any of the following medications (please circle if yes):**

Fosamax, Actonel, Boniva, Aredia, Reclast, Zometa, Prolia other: _____

For how long? _____ When did you stop? _____

7 Please list other medications you are taking:

_____

Have you ever had any of the following? (Circle one Yes or No for each one)

Chest Pains	Yes No	Shortness of Breath	Yes No	Hives/Skin Rashes	Yes No
Heart Failure	Yes No	Ulcers	Yes No	Alcoholism	Yes No
Heart Disease	Yes No	Mental Health Issues	Yes No	Herpes	Yes No
Heart Attack	Yes No	Emphysema	Yes No	Glaucoma	Yes No
Heart Problems	Yes No	Fainting/Dizziness	Yes No	Steroid Treatment	Yes No
Angina Pectoris	Yes No	Eating Disorder	Yes No	Arthritis	Yes No
Heart Surgery	Yes No	Epilepsy/Seizures	Yes No	Dental Implant	Yes No
Liver Disease	Yes No	Persistent Cough	Yes No	Dentures/Partials	Yes No
Hypertension	Yes No	Tuberculosis	Yes No	Birth Defects	Yes No
Heart Murmur	Yes No	Asthma	Yes No	HIV+, AIDS, ARC	Yes No
Rheumatic Fever	Yes No	Hepatitis A	Yes No	Hay Fever	Yes No
Psychiatric Treatment	Yes No	Hepatitis B	Yes No	Tobacco Products	Yes No
Sickle Cell Disease	Yes No	Hepatitis C or D	Yes No	Bruise Easily	Yes No
Sinus Trouble	Yes No	Pacemaker	Yes No	Jaundice	Yes No
Artificial Joints	Yes No	Night Sweats	Yes No	Kidney Trouble	Yes No
Thyroid Disease	Yes No	Stroke	Yes No	Diabetes	Yes No
Anemia	Yes No	Drug Addiction	Yes No	Chemotherapy	Yes No
Blood Transfusion	Yes No	Cold Sores	Yes No	Cancer	Yes No
Mitral Valve Prolapse (MVP)	Yes No	Radiation Therapy	Yes No	Transplant	Yes No

- Dental History (circle one Yes or No for each one) and answers all questions.

1 Date of last dental exam:_____Date of last dental x-rays: _____

2 Previous dentist's name / location:_____

3 Are you having tooth or gum pain at this time? Yes No

4 Do you feel nervous about having dental treatment? Yes No

5 Have you ever had a bad experience in a dental office? Yes No

6 Do your gums bleed when brushing / flossing? Yes No

7 Have you ever seen a periodontist? Yes No

8 Have you ever had a "deep cleaning" (Scaling and Root Planning)? Yes No

9 Is there anything you would like to speak with the Doctor about in private? Yes No

10 Would you be interested in discussing ways to improve your smile? Yes No

If yes, please explain: _____

Do you have any of the following dental concerns: (circle one Yes or No for each one)

Clicking in jaw joint Yes No		Sensitivity to: Hot -Cold –Sweets - Biting	
Pain in or around your ears	Yes No	Swelling Yes No	Bleeding Gums Yes No
Difficulty opening or closing	Yes No	Bad Taste Yes No	Bad Breath Yes No
Difficulty chewing	Yes No	Food Catching Yes No	Tooth Pain Yes No
History of trauma to jaw or face	Yes No	Clenching Yes No	Grinding Yes No

Diagnosis of TMJ/TMD Yes No Other: _____

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

Signature:_____Date_____

DOCTORS NOTES:

Financial Guidelines

Payment for treatment is due and payable the day services are rendered. It is our goal, however, to assist all patients in obtaining the dental treatment they deserve. Therefore, we are pleased to offer several payment options. Please read the following carefully. Our financial coordinator will answer any questions you may have and assist you in selecting the appropriate financial plan for your needs.

For your convenience, we offer the following financial options:

1. In addition to personal checks and cash, we also accept payment through MasterCard/Visa, American Express, and Discover.

2. We offer extended payment plans for upon approved credit or noncredit check. (Care Credit, Lending Club)
3. Dental Insurance

We are happy to file insurance claims and assist you in obtaining the maximum benefits specified in your contract. However, please keep the following in mind:

- **Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract. We will do our best to ESTIMATE your coverage and file your insurance on your behalf. Not all dental services are necessarily covered under your dental insurance plan. It is essential that you read and understand your coverage and pay special attention to any preauthorization requirements, exclusions and waiting periods.**

- **Our office policy states that you are totally responsible for your bill. The ESTIMATED patient portion of the fee is due at the time of service. If a balance remains after we receive payment from your insurance carrier within 30 days, we will notify you. Failure of your insurance carrier to reimburse our office within 30 days will result in our billing you directly for the remaining balance.**

- **We are committed to providing the highest quality of care. Our treatment recommendations and the dental services we provide are in the best interest of the patient's health. The patient is responsible for payment in full regardless of an insurance company's arbitrary determination of treatment necessity. If your coverage changes for any reason, please notify the office immediately**.

Usual and Customary Fees

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area and experience. You are responsible for payment regardless of any insurance company's arbitrary determination for usual and customary fees. All delinquent accounts not paid within 60 days will be taken further action. I have read the Financial Policy. I understand and agree to this Policy.

Payment for Surgery

For any type of surgery, a payment or a payment plan agreement must be made **1 week prior** to the date of your surgery. This ensures your surgery day and time.

Cancellations and Missed Appointments

We require 24 hours advance notice of a cancellation. Patients who do not provide 24 hours' notice of a cancellation or who do not present for a scheduled appointment may be charged a fee. Patients who fail to present for a second appointment may be charged a fee or dismissed from the practice. After the second missed appointment, a letter will be mailed reiterating our policy and reminding the patient of the risk of dismissal should another appointment be missed.

By signing this form, you have read and understand our policy. Any denials or insurance payments less than estimated will be your responsibility. Payment will be due upon our billing cycle. All estimated out of pocket fees and deductibles are due the day of treatment. A payment or payment plan agreement is needed 1 week prior to any Dental Surgeries. Ask our office regarding our financial options before your visit, or if you have any questions regarding your insurance and our policy.

Consent

I understand that responsibility for payment of medical services in this office for myself and my dependents is mine; due and payable at the time of services are rendered unless financial arrangements have been made. I understand that I am responsible for all costs of collection including attorney fees, collection fees of 30% and court costs. I understand that any unpaid balance will be assessed interest at the rate of 18.00% (1.5% monthly). Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance. I also assign all benefits to Provider. I authorize the submission of claims without obtaining my signature on each claim submitted.
I give my authorization and consent for treatment after having a full explanation of proposed treatment, alternatives, and risks by my doctor. I have been advised of my privacy rights as provided by the Healthcare Information Portability and Accountability Act of 1996. I hereby authorize this Provider and its employees, agents, and assignees to contact me via e-mail, text messaging and to my cellular devices.

Signature of Patient or Responsible Party: _____ **Date:** _____

- ## Authorization for Release of Information to Family and/or Friends

Name of Patient_____Date of Birth_____

Northern Colorado Dental and Implant Specialty Center is authorized to discuss my dental care and may release my confidential health information to the following:

_____ _____
Name Relationship

_____ _____
Name Relationship

Signature of Patient or Personal Representative* _____ **Date:** _____

_____
*Description of Personal Representative's Authority (attach necessary documentation)

- ## Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____

State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with a Notice of Privacy Practices. Our Notice is available online. If you prefer a paper copy, please ask a team member for a copy of our Notice.

I acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature_____**Date**_____

----------FOR OFFICE USE ONLY----------

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

☐ Individual refused to sign.

☐ Communication barriers prohibited obtaining the acknowledgment.

☐ An emergency situation prevented us from obtaining the acknowledgment.

☐ Other (Please Specify)

• HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.
What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the Doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ (Sign name) Date_____, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.