Dental Arts of CHERRY HILLS

PATIENT INFORMATION

Date _____

Title: Dr Mr Mrs Ms _____ Gender: M F

Patient _____

Address _____ Unit# _____

City _____ State ____ Zip _____

Employer _____

City _____ State ____ Zip _____

Contact in Case of Emergency _____

Contact Phone ( ) _____

Preferred voice mail/appointment confirmation number:
Please circle: Home Work Cell

Home Phone ( ) _____ - _____

Work Phone ( ) _____ - _____

Cell Phone ( ) _____ - _____

E-mail _____

Social Security # _____-_____-_____

Birth Date mo _____ day _____ year _____

Marital Status: Single Married Divorced Separated Widowed

Person Responsible For The Account or Insurance ***If OTHER*** *Than The Patient*

Guarantor _____

Relationship to Patient _____

Address _____ Unit# _____

City _____ State ____ Zip _____

Employer _____

City _____ State ____ Zip _____

Home Phone ( ) _____ - _____

Work Phone ( ) _____ - _____

Social Security # _____-_____ - _____

Birth Date mo _____ day ____ year _____

Marital Status: Single Married Divorced Separated Widowed

Title: Dr Mr Mrs Ms _____ Gender: M F

Referral Source

Please enter the source that directed you to our office so that we may send a **Thank You Card** and so that we may record how patients find us.

Doctor _____ DDS DMD MD DO DC Other ____

Another Patient _____ Yellow Pages _____ (which book)

Referral Service _____ Other Source _____

Dental Insurance Information

Attach a **completed and signed** form and a copy of the **Benefits** for **Each** company. Failure to compete this section will delay payment of benefits.

Primary Insurance Company _____ Group # _____

Employee _____

Relationship to Patient _____

Insurance Address _____ Unit# _____

City _____ State ____ Zip _____

Employer _____

City _____ State ____ Zip _____

Home Phone ( ) _____ - _____

Work Phone ( ) _____ - _____

Social Security # _____-_____ - _____

Birth Date mo _____ day ____ year _____

Marital Status: Single Married Divorced Separated Widowed

Title: Dr Mr Mrs Ms _____ Gender: M F

Secondary Insurance Company _____ Group # _____

Employee _____

Relationship to Patient _____

Insurance Address _____ Unit# _____

City _____ State ____ Zip _____

Employer _____

City _____ State ____ Zip _____

Home Phone ( ) _____ - _____

Work Phone ( ) _____ - _____

Social Security # _____-_____ - _____

Birth Date mo _____ day ____ year _____

Marital Status: Single Married Divorced Separated Widowed

Title: Dr Mr Mrs Ms _____ Gender: M F

Office Financial Policy

Payment

All Fees are due in full at the time of service unless financial arrangements have been made in advance and signed by both the patient and the office manager.

Insurance

We are pleased to assist you in submitting claims for dental services. Please provide us with a completed and signed form as there are considerable differences between companies. We ask that you pay in full for services during the first few visits (radiographs, models, examination and emergency services). You can be reimbursed directly for any insurance benefits, or you may arrange with our office manager to have insurance benefits credited to your account. It usually takes 3 to 4 weeks to receive your insurance payment.

Prior to starting any elective treatment, we will submit a request to your insurance company for the amount of benefits they will allow for your specified treatment. After we have received the written benefit allowance, we will accept the assignment of benefits as part of your payment. However, if your company fails to pay the benefit within 60 days, we must ask that you pay the full amount. In the event of a delayed payment from your insurance company, any money in excess of your balance due will be refunded to you.

Payment Plans

We offer Master Card, Visa, Discover, American Express and CareCredit. There are several third party payment plans that offer competitive rates. We do not offer any extended payments for treatment in this office.

Overdue Accounts

Any account balance which is unpaid after 60 days, will incur a service charge of 1.7% per month (20.4% per annum) or $5.00 minimum to cover our billing and carrying costs. If you are unable to pay the balance in full, several payment options are available.

Checks returned for insufficient funds will incur an additional $40.00 charge to cover the fees charged by our bank and our direct costs.

Accounts which have not made financial arrangements and which have an unpaid balance after 120 days will be sent to collection. Collection fees equal to the total accrued balance may be added to the amount due. In other words, you will be liable for up to **twice** the amount owed to cover collection costs.

Patient's Acceptance

"I have read the above financial policy and agree to these terms of payment, service charges and collection fees."

Signature _____ Date _____

"I agree to assign all insurance benefits to this office. Any payments in excess of the amount owed will be refunded to me."

Signature _____ Date _____

Clarkson Medical/Dental Center • 3601 South Clarkson, Suite 400 • Englewood, CO 80113 • (303) 789-2020

HEALTH QUESTIONNAIRE

Name _____ Birth date _____

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Circle yes or no, whichever applies, in response to the following questions. Your answers are for our records only and will be considered confidential.

DENTAL

1. Are you having any discomfort at this time ..... Yes No
2. Have you ever had any serious trouble associated with previous dental treatment? ..... Yes No
   If so, explain _____
3. Does dental treatment make you nervous? No_____Slightly_____Moderately _____Extremely _____
4. Date of last dental visit _____
5. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? ..... Yes No
   If so, when? _____
6. How often do you brush _____
   Brush is: Soft ☐ Medium ☐ Hard ☐
7. Do you have or have you ever had any of the following?

MOUTH

Bleeding, sore gums	Yes	No
Unpleasant taste/bad breath	Yes	No
Burning tongue/lips	Yes	No
Frequent blisters, lips/mouth	Yes	No
Swelling/lumps in mouth	Yes	No
Ortho treatments (braces)	Yes	No
Biting cheeks/lips	Yes	No
Clicking/popping jaw	Yes	No
Difficulty opening or closing jaw	Yes	No

TEETH

Loose teeth	Yes	No
Sensitive to hot	Yes	No
Sensitive to cold	Yes	No
Sensitive to sweets	Yes	No
Sensitive to biting	Yes	No
Food impaction	Yes	No
Clenching/grinding	Yes	No
If so, when_____		
Shifting in bite	Yes	No
Change in bite	Yes	No

8. Do you use the following?

Brush	Yes	No
Dental floss	Yes	No
Fluoride rinse	Yes	No

Other _____

MEDICAL

1. Has there been any change in your general health within the past year ..... Yes No
2. My last physical examination was on _____
3. Are you now under the care of a physician ..... Yes No
   If so, what is the condition being treated _____
4. The name and address of my physician is _____
   _____
5. Have you had any serious illness within the past five (5) years ..... Yes No
   If so, what was the illness _____
6. Have you been hospitalized or had an operation within the past five (5) years ..... Yes No
   If so, what was the problem _____
7. Do you have or have you had any of the following diseases or problems
   a. Rheumatic fever or rheumatic heart disease ..... Yes No
   b. Congenital heart disease ..... Yes No
   c. Cardiovascular disease (heart trouble, heart attack, heart murmur, coronary insufficiency, coronary occlusion, high/low blood pressure, arteriosclerosis, stroke, etc.) ..... Yes No
      1) Do you have pain in chest upon exertion ..... Yes No
      2) Are you ever short of breath after mild exercise ..... Yes No
      3) Do your ankles swell ..... Yes No
      4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep ..... Yes No
   d. Artificial or replacement valves ..... Yes No
   e. Pacemaker ..... Yes No
   f. Allergy ..... Yes No
   g. Sinus trouble ..... Yes No
   h. Asthma or hay fever ..... Yes No
   i. Hives or a skin rash ..... Yes No
   j. Fainting spells or seizures ..... Yes No
   k. Diabetes ..... Yes No
      1) Do you have to urinate (pass water) more than six times a day ..... Yes No
      2) Are you thirsty much of the time ..... Yes No
      3) Does your mouth frequently become dry ..... Yes No

(over)

l. Hepatitis, jaundice or liver disease ..... Yes No
m. Arthritis or inflammatory rheumatism ..... Yes No
n. Artificial or replacement joints, prosthetic ..... Yes No
o. Digestive system—Ulcers or stomach disorders (colitis) ..... Yes No
p. Kidney trouble ..... Yes No
q. Tuberculosis ..... Yes No
r. Persistent cough or cough up blood ..... Yes No
s. Immune System disorders (including AIDS, HIV, ARC) ..... Yes No
t. Venereal disease ..... Yes No
u. Other_____ Yes No

8. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma_____ Yes No
   a. Do you bruise easily ..... Yes No
   b. Have you ever required a blood transfusion ..... Yes No
      If so, explain the circumstances & when_____
9. Have you ever tested positive for the AIDS virus ..... Yes No
10. Do you have any blood disorder such as anemia ..... Yes No
11. Have you had surgery or x-ray treatment for a tumor, growth, or other condition ..... Yes No
12. Are you taking any of the following:
    a. Antibiotics or sulfa drugs ..... Yes No
    b. Anticoagulants (blood thinners) ..... Yes No
    c. Medicine for high blood pressure ..... Yes No
    d. Cortisone (steroids) ..... Yes No
    e. Tranquilizers ..... Yes No
    f. Antihistamines ..... Yes No
    g. Aspirin ..... Yes No
    h. Insulin, tolbutamide (Orinase) or similar drug for diabetes ..... Yes No
    i. Digitalis or drugs for heart trouble ..... Yes No
    j. Nitroglycerin ..... Yes No
    k. Other medications_____ Yes No
    l. If "Yes" to any of the above, state drug name, dosage and frequency_____
13. Are you allergic or have you reacted adversely to:
    a. Local anesthetics ..... Yes No
    b. Penicillin or other antibiotics ..... Yes No
    c. Sulfa drugs ..... Yes No
    d. Barbiturates, sedatives, or sleeping pills ..... Yes No
    e. Aspirin ..... Yes No
    f. Iodine ..... Yes No
    g. Codeine or other narcotics Yes No
    h. Other_____ Yes No
14. Do you use any tobacco products ..... Yes No
    If so, how much per day and what _____
15. Do you use any alcohol products ..... Yes No
    If so, how much per day/week/month and what _____
16. Do you use any caffeinated products (coffee, tea, chocolate, etc.) ..... Yes No
    If so, how much per day and what _____
17. Do you have any disease, condition, or problem not listed above that you think I should know about ..... Yes No
    If so, explain _____
    _____
18. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation ..... Yes No
19. Are you wearing contact lenses ..... Yes No
20. Are you experiencing stress or pressure in your work or at home ..... Yes No

WOMEN

21. Are you pregnant ..... Yes No
22. Do you have PMS or problems associated with your menstrual period ..... Yes No
23. Are you taking birth control or hormone therapy ..... Yes No

Remarks:

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

_____ _____

Signature of Patient Date Signature of Dentist Date

Dental Arts of Cherry Hills

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Dental Arts of Cherry Hills

NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/03, and will remain in effect until we replace it.

We reserve the right 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 the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.