DENALIDENTAL

Patient Information:

Today's Date: _____

Name: _____ Preferred Name: _____

Date of Birth: ____/____/____ Age: _____ SS#_____ Driver License#_____

Home Address: _____ City_____ Zip_____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Cell Phone: (_____) _____-_____ Email: _____

Employer_____ Address_____

Occupation_____ Spouse's Name_____ Phone_____

Parent or Guardian if under 18 Years of age_____

Emergency Contact _____ Relationship_____

Address_____ Phone_____

How Did You Hear About Us? _____

Insurance Information

Primary Dental Insurance

Insured's
Name_____
Birth Date_____ SS#_____
Employer _____
Policy #_____
Insurance Company
Name_____
Phone #_____
Insurance Company
Address_____

Secondary Dental Insurance

Insured's
Name_____
Birth Date_____ SS#_____
Employer _____
Policy #_____
Insurance Company
Name_____
Phone #_____
Insurance Company
Address_____

THE INFORMATION I HAVE GIVEN TODAY IS CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT I MUST INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS

Consent

The undersigned hereby authorizes the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all form of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate credit reports may be obtained.

Patient Signature (Parent or Guardian): _____Date: _____

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Medical History

Are you Under a Physician's Care now? Yes/No Family Physician _____Phone Number_____

-Do you use: Cigars/Cigarettes: Yes/No -Pipe: Yes/No -Chewing Tobacco: Yes/No -Marijuana: Yes/No

Women: -Are You Pregnant? Yes /No -Nursing? Yes/No -Oral Contraceptives? Yes/No

Have you ever been hospitalized or had a major operation? Yes / No When: _____

Have you ever had a serious head or neck Injury? Yes / No When: _____

Are you taking any medications, pills, or drugs? _____

_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No

Please note any & all allergies: _____

Aids/HIV Positive	Yes No	Excessive Bleeding	Yes No	Low Blood Pressure	Yes No
Alzheimer's Disease	Yes No	Excessive Thirst	Yes No	Lung Disease	Yes No
Anaphylaxis	Yes No	Fainting Spells/Dizzy	Yes No	Mitral Valve Prolapse	Yes No
Anemia	Yes No	Frequent Cough	Yes No	Osteoporosis	Yes No
Angina	Yes No	Frequent Diarrhea	Yes No	Pain in Jaw Joints	Yes No
Arthritis/Gout	Yes No	Frequent Headaches	Yes No	Parathyroid Disease	Yes No
Artificial Heart Valve	Yes No	Genital Herpes	Yes No	Psychiatric Care	Yes No
Artificial Joint	Yes No	Glaucoma	Yes No	Radiation Treatments	Yes No
Asthma	Yes No	Hay Fever	Yes No	Recent Weight Loss	Yes No
Blood Disease	Yes No	Heart Attack/Failure	Yes No	Renal Dialysis	Yes No
Blood Transfusion	Yes No	Heart Murmur	Yes No	Rheumatic Fever	Yes No
Breathing Problems	Yes No	Heart Pacemaker	Yes No	Scarlet Fever	Yes No
Bruise Easily	Yes No	Heart Trouble/Disease	Yes No	Shingles	Yes No
Cancer	Yes No	Hemophilia	Yes No	Sickle Cell Disease	Yes No
Chemotherapy	Yes No	Hepatitis A	Yes No	Sinus Trouble	Yes No
Chest Pain	Yes No	Hepatitis B or C	Yes No	Spina Bifida	Yes No
Cold Sores/Fever Blisters	Yes No	Herpes	Yes No	Stomach/Intestinal Disease	Yes No
Congenital Heart Disorder	Yes No	High Blood Pressure	Yes No	Stroke	Yes No
Convulsions	Yes No	High Cholesterol	Yes No	Swelling of limbs	Yes No
Cortisone Medicine	Yes No	Hives or Rash	Yes No	Thyroid Disease	Yes No
Diabetes	Yes No	Hypoglycemia	Yes No	Tonsillitis	Yes No
Drug Addiction	Yes No	Irregular Heartbeat	Yes No	Tumors or Growths	Yes No
Easily Winded	Yes No	Kidney Problems	Yes No	Ulcers	Yes No
Emphysema	Yes No	Leukemia	Yes No	Venereal Disease	Yes No
Epilepsy or Seizures	Yes No	Liver Disease	Yes No	Yellow Jaundice	Yes No

Have you ever had any serious illness not listed about? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or Patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian _____ Date_____

DENALIDENTAL

Office Policy

Payment well be expected at the time of service for all non-contracted fees and co-pays.

Insurance Contracts: If we have a "Participating Contract" with your Insurance carrier, we will accept assignment on all Covered Services and bill your Carrier for you. You are responsible for the Co-Pay, Coinsurance, and Deductible and for all non-covered services.

If your insurance is found to not be active on the date your dental services are provided, you will be responsible for the full balance based on usual and customary fees. A finance charge of 18% APR (1.5% a month) will be added to the total balance on all accounts over 60 days past due.

Third party financing is available for patients requiring extensive treatment.

If at any time you have questions regarding any treatment, fees, or services, please discuss them with us promptly and frankly. We will make every effort to avoid a misunderstanding, to rectify an injustice, or to preserve a friendship.

Missed Appointments: For any patients that participate with PPO insurance, our policy is a $50 charge per hour of scheduled time without a 24 hour-advance notice. For patients participating with Health First Colorado, or Dentaquest, our policy is to report any broken appointment without a 24 hour-advance notice.

Broken Appointments: Broken appointments can be defined as an appointment that was cancelled the day of the scheduled date of service due to a foreseen excuse. After 3 broken appointments we will discharge you as a patient, if you have any questions about this please contact our office.

Children in the office: Please make arrangements for your non-scheduled children prior to your visit. Children should not be left unattended in the reception area. All children 17 years of age and under scheduled for treatment must have a parent or legal guardian present in the office during their appointment.

Cellular phones: We request all cellular phones be turned off or to silent mode during your appointment.

We reserve the right to dismiss any patient from our practice for inappropriate behavior in our office or on the phone.

I acknowledge that I am responsible to pay all charges for treatment administered by Denali Dental as outlined above and that if my account is placed with a collection agency for non-payment that I will be held responsible for all collection costs, including court costs and associated attorney fees.

I have read the policies and agree with the terms outlined above.

Responsible Party Printed Name: _____

Responsible Party Signature: _____

Date: _____

Notice of Privacy Practices

This notice describes how Medical/Dental Information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

We understand that the privacy of your personal information is important to you. As your Dental office, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to call the office at (303)254-4444.

Information We Collect About You

- We collect personal information about you and your family as part of our new patient process, during your care, and from other health care entities you utilize such as, other dentists and specialists, imaging facilities, laboratories, and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy, and coverage information and any information you provide. During your treatment we will collect dental information regarding diagnosis, treatment plans, progress, and any test results or films.

How Your Information is Used

- The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other Dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked at any time with a written request. Denali Dental does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest, we may be required to disclose certain information to local, state, or national health organizations or government agencies.

We may contact you to provide appointment reminders or information about treatment.

Safeguarding Your Personal and Health Information

We are required by law to

- Make sure that medical information that identifies you is kept private
- Provide you with your privacy policy
- Follow the terms laid out in the Privacy Policy

As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you.

Denali Dental maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated, you have the right to file a complaint with the Department of Health and Human Services. The complain in no way influences your course of treatment with Denali Dental.

As of July 1, 2011, the State of Colorado requires that anyone who is prescribed a controlled substance (narcotic) will have their information entered into a nationwide database. The Drug Prescription Monitoring database is very secure, as only physicians and law enforcement can access the database. If you do not wish to have your information entered into this database, please inform the doctor and he will prescribe you a non-narcotic.

If you have any questions, you can contact the Colorado State Department of Regulatory Agencies by calling (303)894-7855
Changes to Our Privacy Policy. All new patients will receive a copy of notice of privacy policy. Denali Dental occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

Your Right to Restrict Use of Information

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Acknowledgement of Receipt of Notice of Privacy Practices

****You May Refuse to Sign This Acknowledgment****

If the patient is under the age of 18, a parent or legal guardian must sign.

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

Signature of Patient or Parent/Legal Guardian: _____

Date: _____

For Patients Who Need to Pre-Medicate Only:

I am authorizing this office to call me and remind me to take my pre-medication before my dental appointment. They may leave a message for me regarding this information at any number that I have supplied to them. They may leave a message on any answering machine, voice mailbox or with whoever answers the telephone. I also authorize this office to remind me of my pre-medication on any postcard reminders that the office will mail to me.

Printed Name: _____

Signature of Patient or Parent/Legal Guardian: _____

For Office Use Only:

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

- o Individual refused to sign
- o Communications barriers prohibited obtaining the acknowledgement
- o An emergency prevented us from obtaining acknowledgement
- o Patient reviewed Privacy Practices but elected not to take a copy home
- o Other (Please Specify)

Employee Signature: _____ Date: _____
