DENVER DENTAL CARE

Patient Information:

Patient Name: _____
Last First Middle

Preferred Name: _____ Male_____ Female_____

Date of Birth: _____ Age: _____ SSN: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

PERSON RESPONSIBLE FOR THE ACCOUNT: Skip if same as above

Name: _____ Relationship: _____

Billing Address: _____

SSN: _____ Primary Phone: _____

Emergency Contact:_____

Name: _____ Relationship: _____

Primary Phone: _____

Primary Care Physician: _____ Phone: _____

OFFICE POLICY: We value our patients! If you have insurance, please understand that we don't work for an insurance company; rather, we work 100% for our patients. The treatment we recommend will always be based on your individual needs, not your insurance coverage. We are happy to file your claim as a courtesy and will assist you with any questions you may have, but cannot control how insurance processes claims once received.
We require 24hr notice if you need to cancel/reschedule your appointment. Less than 24hr notice of cancellation/reschedule or a 'No Show' will result in a $25.00 charge or a $100.00 charge for appointments scheduled for 2hrs.For appointments that require 3hrs or more, a deposit of $200 will be collected at scheduling. In the event of late cancellation, the deposit will then serve as the cancellation fee. Otherwise, it will be a payment towards the completed treatment.

We do not accept personal checks, cash is welcome and will receive a 5% discount
Thank you for understanding.

Signature:_____ Date: _____

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MEDICAL HISTORY: _____

Do you have or have ever had any of the following medical conditions? Please Circle: Y/N

ALCOHOL/ DRUG ABUSE	Y / N	CANCER/ CHEMOTHERAPY	Y / N	BLOOD THINNERS	Y / N
DIABETES/ HYPOGLYCEMIA	Y / N	STOMACH PROBLEMS/ ULCERS	Y / N	RHEUMATIC FEVER	Y / N
HEART ATTACK	Y / N	RESPIRATORY/BREATHING PROBLEMS	Y / N	EMPHYSEMA/ ASTHMA	Y / N
HEART DEFECT/ DISEASE	Y / N	ARTIFICIAL JOINTS	Y / N	KIDNEY PROBLEMS	Y / N
HEART SURGERY/ ARTIFICIAL VALVES	Y / N	HIGH BLOOD PRESSURE	Y / N	LIVER PROBLEMS	Y / N
HIGH CHOLESTEROL	Y / N	LOW BLOOD PRESSURE	Y / N	SHINGLES	Y / N
HIV/ AIDS/ ARC/ HEPATITIS	Y / N	FAINTING/ SEIZURES/ EPILEPSY	Y / N	ANEMIA	Y / N
JAW PROBLEMS TMJ/TMD	Y / N	ARTHRITIS/RHEUMATISM	Y / N	CHEST PAINS	Y / N
MVP/HEART MURMUR	Y / N	BLEEDING PROBLEMS	Y / N	TUBERCULOSIS	Y / N
SEVERE/FREQUENT HEADACHES	Y / N	PACEMAKER	Y / N	AUTISM	Y / N
STROKE	Y / N	THYROID PROBLEMS	Y / N	ADD/ ADHD	Y / N

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING: _____

_____

_____

HAVE YOU EVER TAKEN BISPHOSPHONATES FOR BONE LOSS? Y / N

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? NO ALLERGIES _____

LATEX	Y / N	CODEINE	Y / N	TETRACYCLINE	Y / N	DENTAL ANESTHETICS	Y / N
ASPIRIN	Y / N	SULFA DRUGS	Y / N	PENICILLIN/ AMOXICILLIN	Y / N	OTHER:	

DO YOU USE TOBACCO? Y / N HOW MUCH? _____ HOW LONG? _____

FOR WOMEN: PREGNANT? Y / N NURSING? Y / N TAKING BIRTH CONTROL? Y / N

IS THERE ANYTHING YOU WOULD LIKE TO CHANGE ABOUT YOUR SMILE? _____

How did you hear about us? _____

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HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES
CONSENT/LIMITED AUTHORIZATION AND RELEASE FORM

You may refuse to sign this acknowledgement and authorization.
In refusing, we may not be allowed to process your insurance claims.

Date: _____ Patient Name: _____

How do you want to be addressed when summoned from reception area:
☐ First name only ☐ Proper Surname ☐ Other: _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (this includes step parents, grandparents, and any care takers who can have access):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM APPOINTMENTS, TREATMENT, AND BILLING INFORMATION:**
☐ Cell Phone ☐ Text Message ☐ Email ☐ Home Phone ☐ Work Phone ☐ All

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED:
☐ Cell Phone ☐ Text Message ☐ Email ☐ Home Phone ☐ Work Phone ☐ All

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, OR NEW HEALTH INFO:**
☐ Cell Phone ☐ Text Message ☐ Email ☐ Home Phone ☐ Work Phone ☐ All ☐ None (opt out)

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed and dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

_____ _____
PRINT Patient Name Patient/Legal Guardian **SIGNATURE**

_____ _____
PRINT Legal Guardian Name **RELATIONSHIP** of Legal Guardian

OFFICE USE ONLY
As Privacy Officer, I attempted to obtain patient's or representative's signature on this Acknowledgement but did not because:
☐ It was emergency treatment ☐ I could not communicate with the patient ☐ The patient refused to sign
☐ The patient was unable to sign because _____
☐ Other (please describe): _____
Signature of Privacy Officer _____