ACQUAINTANCE INFORMATION

Patient Information

Date_____

Patient's Name _____
Last First Middle

Preferred Name_____ Birthdate _____

Address _____
Street City State Zip

Telephone _____/_____/_____ Social Security #: _____
Home Cell Work

Email:_____

How did you learn about our office?_____ Family Dentist: _____

If from a friend or relative, his/her name _____

Responsible Party Information (If Minor)

Name _____ _____
Last First Middle Marital Status

Residence (if different)_____
Street City State Zip

Mailing Address (if different) _____
Street City State Zip

Home Phone_____ Cell Phone _____ Work Phone _____

Social Security #_____ Birthdate_____ Relationship to Patient _____

Dental Insurance Information

Primary Insurance

Insured's Name_____

Insured's SSN/Subscriber ID_____

Date of Birth _____

Relationship to Subscriber Self Spouse Child Other

Employer Name_____

Employer Phone_____

Insurance Company_____

Insurance Group _____

Insurance Phone _____

Secondary Insurance

Insured's Name_____

Insured's SSN/Subscriber ID_____

Date of Birth _____

Relationship to Subscriber Self Spouse Child Other

Employer Name _____ _____

Employer Phone_____

Insurance Company_____

Insurance Group _____

Insurance Phone _____

Emergency Information

Last Name:_____ First Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advised, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

Signature *(Parent's signature if minor)*_____

Updates *(date & initial)* _____ _____ _____ _____ _____

MEDICAL HISTORY

PATIENT _____ DATE _____

NAME OF PHYSICIAN _____ PHONE _____

CLINIC OR FACILITY NAME _____

WHOM MAY WE NOTIFY IN Name _____ PHONE _____

CASE OF AN EMERGENCY? Relationship to you _____

Circle a definite answer for each question:

Yes No ANY CHANGE IN YOUR HEALTH IN THE LAST TWO YEARS?

Yes No ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? IF YES, DESCRIBE YOUR TREATMENT_____

_____

Yes No HAVE YOU HAD ANY MEDICAL TREATMENT OR PHYSICIAN VISIT OF ANY KIND IN THE LAST TWO YEARS? IF YES, DESCRIBE

_____

Yes No HAVE YOU EVER HAD ANY SURGICAL OPERATION OF ANY KIND? IF YES,
DESCRIBE _____

Yes No WERE YOU TRANSFUSED AT THAT TIME? IF YES, WHEN? _____

Yes No ARE YOU CURRENTLY OR HAVE YOU EVER TAKEN BISPHOSPHONATES? IF YES, NAME? _____

Yes No DO YOU NEED TO TAKE PRE-MEDICATION ANTIBIOTICS PRIOR TO DENTAL APPOINTMENT? IF YES, WHAT IS THE NAME OF
ANTIBIOTICS? _____

Yes No HAVE YOU BEEN ADVISED BY A PHYSICIAN OF THE NEED FOR ANY TYPE OF SURGERY OR
TREATMENT? FOR WHAT? _____

Yes No ANY FAMILY HISTORY OF PERIODONTAL DISEASE? IF YES, WHOM? _____

DO YOU HAVE, HAVE YOU HAD, OR BEEN TREATED FOR, ANY OF THE FOLLOWING?:

Yes	No	OSTEOARTHRITIS, RHEUMATOID ARTHRITIS	Yes	No	THYROID CONDITION
Yes	No	RHEUMATIC FEVER, HEART MURMUR	Yes	No	VENEREAL DISEASE, HERPES II
Yes	No	HEART PROBLEMS	Yes	No	HIV, ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)
Yes	No	HIGH BLOOD PRESSURE	Yes	No	PACEMAKER TYPE
Yes	No	LOW BLOOD PRESSURE	Yes	No	HIP OR JOINT REPLACEMENT
Yes	No	MITRAL VALVE PROLAPSE	Yes	No	CANCER, RADIATION OR CHEMOTHERAPY
Yes	No	EPILEPSY, SEIZURES	Yes	No	FAINTING SPELLS
Yes	Nka	ALLERGY	Yes	No	CHEMICAL DEPENDENCY
Yes	No	DIABETES	Yes	No	CHRONIC DIARRHEA
Yes	No	HEPATITIS, LIVER DISEASE	Yes	No	HYPOTHERMIA
Yes	No	ULCERS, GERD, ACID REFLUX, DIGESTIVE PROBLEMS	Yes	No	EAR INFECTIONS
Yes	No	KIDNEY DISORDER	Yes	No	CHRONIC SINUS
Yes	No	TUBERCULOSIS	Yes	No	ASTHMA
Yes	No	ENZYME DEFICIENCY	Yes	No	HEMOPHILIA, BLEEDING OR BLOOD DISORDER
Yes	No	STROKE	Yes	No	ANEMIA, SICKLE CELL DISEASE
Yes	No	HYDROCEPHALUS	Yes	No	PARKINSON'S DISEASE, TREMOR
Yes	No	ANOREXIA, BULIMIA	Yes	No	RESTLESS LEGS SYNDROME, MUSCLE TWITCH
Yes	No	SNORING, SLEEP APNEA	Yes	No	OTHER: _____

Yes No DO YOU USE AN ORAL APPLIANCE TO SLEEP? (Examples: CPAP, Night Guard, Orthodontic Retainers) _____

_____

Yes Nka HAVE YOU EVER HAD AN **ALLERGIC REACTION OR BEEN TOLD NOT TO TAKE ANY MEDICATION**? IF YES, DESCRIBE _____

_____

Yes No ARE YOU **CURRENTLY TAKING ANY PRESCRIPTION DRUGS OF ANY KIND** (Example: Birth Control, Hormone, Diet)?
IF YES, WHAT? _____

Yes No ARE YOU **CURRENTLY TAKING ANY NONPRESCRIPTION DRUGS OF ANY KIND**
(Example: Aspirin, Ibuprofen, Tylenol, Aleve, Cough Syrup, Nasal Spray, Recreational Drug Use)?
IF YES, WHAT? _____

_____

Yes No ARE YOU PREGNANT? ANTICIPATED DELIVERY DATE _____

Yes No DO YOU USE ANY TOBACCO PRODUCT? DAILY INTAKE _____

Yes No DO YOU WEAR CONTACT LENSES?

BLOOD PRESSURE: S_____/D_____/_____

I CERTIFY THE ABOVE TO BE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE_____ DATE _____

Patient or Guardian of Minor

Name of Practice: Denver Periodontics and Implant Dentistry

Patient: **Date of Birth: / /**

Acknowledgment of Notice of Privacy Practices

I hereby acknowledge that I received Denver Periodontics and Implant Dentistry's Notice of Privacy Practices.

_____

Signature of patient or patient representative

Documentation of Good Faith Efforts To obtain patient's acknowledgment that they received provider's Notice of Privacy Practices

(For use when acknowledgment cannot be obtained from the patient.)

The patient presented to the office/hospital on [insert date] and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

☐ Patient refused to sign.

☐ Patient was unable to sign or initial because:

☐ The patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity.

☐ Other reason _____

_____

Signature of Employee Completing Form

[Note: Providers are required to make good faith efforts to obtain acknowledgement that each patient has received their Notice of Privacy Practices. Should the individual refuse to acknowledge receipt of provider's Notice of Privacy Practices, the provider should document the "Good Faith Efforts" taken to obtain such acknowledgement. The regulation does not specific how those "Good Faith Efforts" should be documented. This example form is meant to serve as an example of one way that a provider could satisfy this requirement.]

Denver Periodontics & Implant Dentistry

HIPAA Release Form

Patient Name: _____ DOB: _____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information.

This information may be released to:

☐ **Spouse _____**

☐ **Child(ren) _____**

☐ **Other _____**

☐ **Information is not to be released to anyone.**

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call:

☐ **My home**

☐ **My work**

☐ **My cell number: _____**

If unable to reach me:

☐ **You may leave a detailed message**

☐ **Please leave a message asking me to return your call**

☐ **Do not leave a message**

Signature: _____ Date: _____

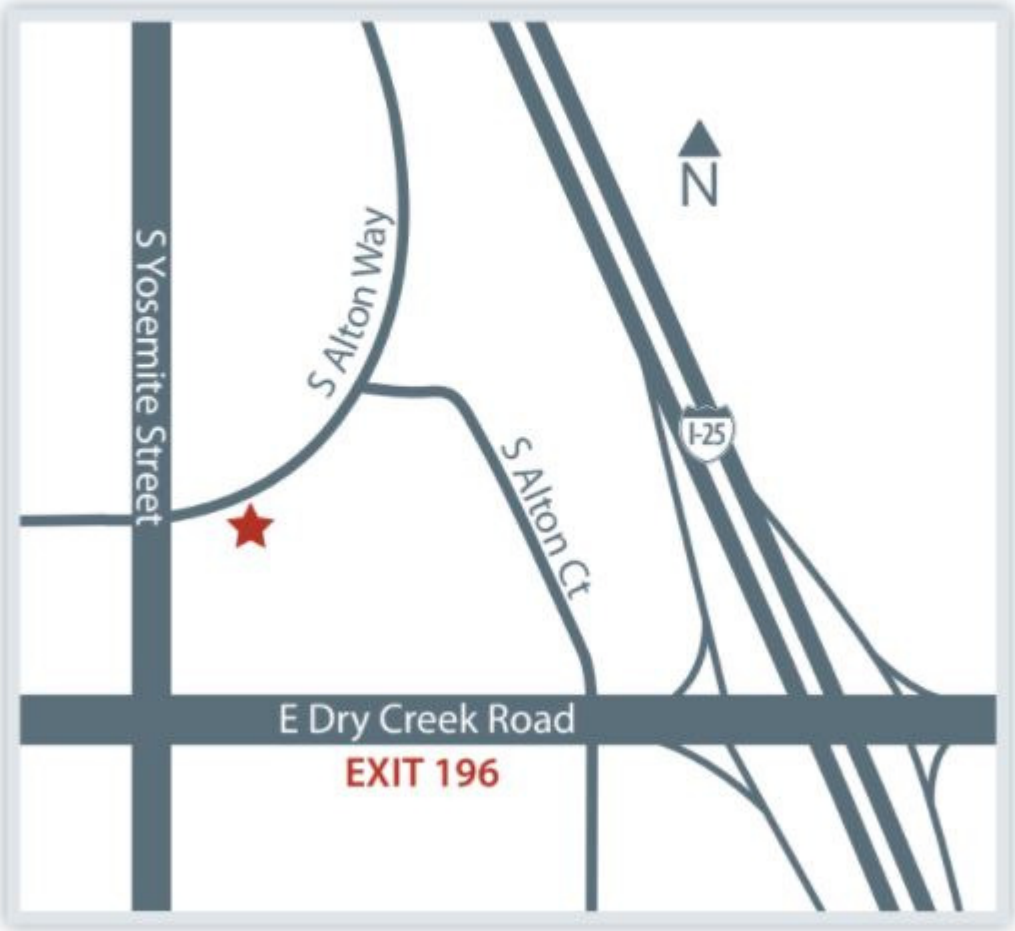
OFFICE FINANCIAL POLICY

Insurance: As a courtesy to our patients, we will bill your insurance. Please bear in mind that there are many different plans and policies. Insurance benefits are determined by your employer, not your dentist. Your insurance policy is a contract between you, your employer, and the insurance company. Insurance is not a guarantee of payment; it often does not cover all the costs involved in treatment. Ultimately, you are responsible for all charges. Some, and perhaps all, of the services provided may not be covered by your insurance company, in which case you will be responsible for the charges for these services. Although we gather as much information as possible regarding your insurance, it is ultimately your responsibility to know which services your insurance policy covers.

Payment: Payment is due when service is provided. If you have insurance, we will collect from you the amount **estimated** as your initial responsibility. Any amount not paid by your insurance, in accordance with your policy, is your responsibility and due upon receipt of a statement from our office. If payment from your insurance company is not received within 60 days from date of service, you may be expected to pay the balance in full. Balances carried over 90 days are considered delinquent and will be subject to a monthly interest of 1.5% (APR 18%). If payment is delinquent, you will be responsible for payment of collection, attorney's fees, and court costs associated with the recovery of the monies due on the account. We accept cash, checks, Visa, MasterCard, American Express and Discover.

Signature of Patient, Parent or Guardian Date

DENVER
PERIODONTICS & IMPLANT
DENTISTRY



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