PATIENT'S NAME____

Last First Initial Date of Birth

Please comment on all yes answers in the space below.

CIRCLE THE APPROPRIATE ANSWER

1. Reason for today's visit:______________________________
2. How long since your last dental visit? ______________________________
3. What was done at that time? ______________________________
4. Was there any recommended dental treatment not completed? YES NO
5. Were dental x-rays taken? YES NO
6. When was the last time your teeth were cleaned? ______________________________
7. Previous dentist's name ______________________________
   Address ______________________________
   ______________________________ Phone ______________________________
8. Have any of your teeth been lost or removed? YES NO
9. If yes, have they been replaced? YES NO
10. Do you clench or grind your teeth? YES NO
11. Are your teeth sensitive to: hot ___ cold ___ sweets ___ pressure ___
12. Does your jaw click or pop? YES NO
13. Do you have frequent head, neck, or shoulder aches? YES NO
14. Have you had any orthodontic treatment? YES NO
15. Does food frequently get caught between your teeth? YES NO
16. Do your gums bleed or hurt? YES NO
17. Are any of your teeth loose, tipped or shifted? YES NO
18. Do you feel your breath is routinely offensive? YES NO
19. Have you ever had gum treatment or surgery? YES NO
    If yes, what was done and when? ______________________________
20. How often and when do you brush your teeth? YES NO
21. Do you use dental floss? YES NO
22. How do you feel about your teeth in general? YES NO
23. Have you had any unpleasant dental experiences or is there anything we have not covered in this form? YES NO
24. Is there anything else we should know about your health that we have not covered in this form? YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S SIGNATURE ______________________________ DATE ______________

DENTIST'S SIGNATURE ______________________________ DATE ______________

DENTAL HISTORY

MEDICAL HISTORY

Patient Name: ______________________________ DOB: ______________________ Date Created: ____________

Although dental personnel primarily treat the area in and around your mouth, your mouth is an important part of your entire body. Health problems that you may have, or medication(s) you may be on can DIRECTLY affect your oral health, they could have an important interrelationship with the dental care you will receive. In advance thank you for carefully answering these questions.

Are you under a physician's care now? ◯Yes ◯No If yes: ____

Have you ever been hospitalized or had a major operation? ◯Yes ◯No If yes: ______________________________

Have you ever had a serious head or neck injury? ◯Yes ◯No If yes: ____________________________________

Are you taking any medications, pills, or drugs? ◯Yes ◯No If yes: ____________________________________

Do you take, or have you taken, Phen-Fen or Redux? ◯Yes ◯No If yes: __________________________________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Please list years taken?
◯Yes ◯No If yes: ____

Are you on any special diets? ◯Yes ◯No If yes: ____

Do you use any types of tobacco? ◯Yes ◯No If yes: ____

Women: Please answer the following: ◯ pregnant/ Trying to become pregnant? ◯ Nursing ◯ Taking Oral Contraceptives

Are you allergic to any of the following?
◯Aspirin ◯ Metal ◯ Latex ◯ Penicillin ◯ Codeine ◯ Sulfa Drugs ◯ Acrylic ◯ Local Anesthetics ◯ Other __________

Do you use controlled substances? ◯Yes ◯No If yes:____

Do you have, or have you had any of the following?

AIDS/ HIV	◯Yes ◯No	Emphysema	◯Yes ◯No	Mitral Valve Prolapse	◯Yes ◯No
Cortisone Medicine	◯Yes ◯No	Epilepsy/ Seizures	◯Yes ◯No	Osteoporosis	◯Yes ◯No
Hemophilia	◯Yes ◯No	Excessive Bleeding	◯Yes ◯No	Pain in Jaw and Joints	◯Yes ◯No
Renal Dialysis	◯Yes ◯No	Excessive Thirst	◯Yes ◯No	Parathyroid Disease	◯Yes ◯No
Rheumatic Fever	◯Yes ◯No	Fainting Spells	◯Yes ◯No	Psychiatric Care	◯Yes ◯No
Anaphylaxis	◯Yes ◯No	Frequent Cough	◯Yes ◯No	Rheumatism	◯Yes ◯No
Anemia	◯Yes ◯No	Frequent Diarrhea	◯Yes ◯No	Scarlet Fever	◯Yes ◯No
Angina	◯Yes ◯No	Frequent Headaches	◯Yes ◯No	Shingles	◯Yes ◯No
Arthritis/ Gout	◯Yes ◯No	Genital Herpes	◯Yes ◯No	Sickle Cell Disease	◯Yes ◯No
Artificial Heart Valve	◯Yes ◯No	Glaucoma	◯Yes ◯No	Sinus Trouble	◯Yes ◯No
Artificial Joint	◯Yes ◯No	Hayfever	◯Yes ◯No	Spina Bifida	◯Yes ◯No
Asthma	◯Yes ◯No	Heart Attack	◯Yes ◯No	Stomach Disease	◯Yes ◯No
Blood Disease	◯Yes ◯No	Heart Murmur	◯Yes ◯No	Stroke	◯Yes ◯No
Blood Transfusion	◯Yes ◯No	Heart Pacemaker	◯Yes ◯No	Swelling of Limbs	◯Yes ◯No
Breathing Problems	◯Yes ◯No	Heart Disease	◯Yes ◯No	Thyroid Disease	◯Yes ◯No
Bruise Easy	◯Yes ◯No	Herpes	◯Yes ◯No	Tonsillitis	◯Yes ◯No
Cancer	◯Yes ◯No	High Blood Pressure	◯Yes ◯No	Tuberculosis	◯Yes ◯No
Chemotherapy	◯Yes ◯No	High Cholesterol	◯Yes ◯No	Tumors/ Growth	◯Yes ◯No
Chest Pain	◯Yes ◯No	Hive/ Rash	◯Yes ◯No	Ulcers	◯Yes ◯No
Cold Sores	◯Yes ◯No	Hypoglycemia	◯Yes ◯No	Venereal Disease	◯Yes ◯No
Congenital Heart		Kidney Problems	◯Yes ◯No	Jaundice	◯Yes ◯No
Disorder	◯Yes ◯No	Leukemia	◯Yes ◯No	Radiation Treatments	◯Yes ◯No
Convulsions	◯Yes ◯No	Liver Disease	◯Yes ◯No	Alzheimer's	◯Yes ◯No
Drug Addiction	◯Yes ◯No	Low Blood Pressure	◯Yes ◯No	Diabetes	◯Yes ◯No
Easily Winded	◯Yes ◯No	Lung Disease	◯Yes ◯No	Hepatitis A	◯Yes ◯No

Have you ever had a serious illness or injury not listed? ◯Yes ◯No If yes ________________________________

Comments:

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

Signature of Patient, Parent, or Guardian: X________________________________ Date: __________

PATIENT INFORMATION
(Person being seen for visit)

NAME____
Last First Initial

HOW DO YOU WISH TO BE ADDRESSED____

CIRCLE: Single Married Divorced Widowed Minor GENDER: Male Female

Social Security #____________________Date of Birth________________ Age____________________

ADDRESS—STREET____

CITY______________________________STATE____________ZIP__________________________

PHONE: HOME_____________WORK___________CELL____________ Drivers Lic.#___________

BEST TIME TO CALL_______________EMAIL____

GUARANTOR INFORMATION
(Person responsible for the account)

NAME____
Last First Initial

CIRCLE: Single Married Divorced Widowed Minor GENDER: Male Female

Social Security #___________________Date of Birth________________ Age______________________

ADDRESS—STREET____

CITY______________________________STATE____________ZIP____________________________

PHONE: HOME_____________WORK___________CELL____________ Drivers Lic.#___________

BEST TIME TO CALL_______________EMAIL____

EMPLOYMENT INFORMATION FOR GUARANTOR

NAME OF EMPLOYER________________________________ADDRESS________________________

CITY______________________STATE___ZIP___________PHONE______________FAX_________

REGISTRATION

EMERGENCY INFORMATION
(Someone to notify in case of emergency)

NAME____

ADDRESS____

PHONE: HOME______________________WORK___________________CELL_____________

REFERRAL INFORMATION
(Whom may we thank for this referral)

NAME________________________________ADDRESS________________________________

____yellow pages ____benefits manager ____insurance co. ____direct mail ____internet

Other____

PRIMARY DENTAL PLAN/INSURANCE

NAME OF DENTAL PLAN/INSURANCE____

ADDRESS TO SEND CLAIMS (if applicable) _____________________________________

CITY___________________STATE_________ZIP__________PHONE______________________

NAME OF INSURED SUBSCRIBER____

CIRCLE RELATIONSHIP TO SUBSCRIBER: Self Spouse Child

POLICY/GROUP NUMBER_____________________INSURED'S SS# OR ID#_________________

SECONDARY DENTAL PLAN/INSURANCE

NAME OF DENTAL PLAN/INSURANCE____

ADDRESS TO SEND CLAIMS (if applicable) _____________________________________

CITY___________________STATE_________ZIP__________PHONE______________________

NAME OF INSURED SUBSCRIBER____

CIRCLE RELATIONSHIP TO SUBSCRIBER: Self Spouse Child

POLICY/GROUP NUMBER_____________________INSURED'S SS# OR ID#_________________

REGISTRATION

RELEASE

1. I authorize the dentist to perform diagnostic procedures and treatment as may be deemed necessary for proper dental care.
2. I authorize release of any information concerning my (or my child's) healthcare, advice, and treatment to another dentist.
3. I authorize the dental group and/or its agents to transmit patient billing and/or insurance information to my insurance carrier electronic communication address in lieu of U.S. Postal Service.
4. I authorize the dental group to communicate through the use of electronic mail; appointment reminders, bills and other financial information, unfinished treatment plans which may contain information related to health issues identified by my dentist during previous appointments, and any other necessary information related to my dental treatment that my dentist believes necessary. I am providing the e-mail address listed below for that purpose. I understand that it is my responsibility to notify my dentist when my e-mail address changes as soon as is practical. I understand that e-mail is being used for my convenience and privacy and improved efficiency in communicating with my dentist. I will not hold the dentist responsible for disclosures that occur due to other individuals reading e-mails sent to the address provided below
5. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services.
6. I understand that I am financially responsible for payments in full of my dental account.
7. By signing this statement, I agree to be responsible for payment of services not paid, in whole or in part, by my dental plan payer.

____ ________________

Patient's or Guardian's Signature Date

SIGNATURE ON FILE

Dental Health Centers is authorized to provide any insurance company, administrator, and consulting health care professional, information concerning health care advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits. This authorization is valid for the term of coverage of the policy or contract in force on this date only. I know I have the right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is as valid as the original.

Patient's or Guardian's Signature

I hereby authorize payment directly to Dental Health Centers of the dental benefits otherwise payable to me.

Insured's Signature

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to disclose and use protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent in writing, at any time. However, any use or disclosure that occurred prior to this date I revoked this consent, is not in effect.

Signed this date: _________________________

Print Patient Name: ____

Relationship to Patient: _____________________________________

Signature: ____

Practice Name: ____

For Office Use Only

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

- ❑ Individual Refused to Sign
- ❑ Communication barriers prohibited obtaining acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify)

____

____

Greeley Dental Health Financial Policy

We would like to take this opportunity to welcome you to our office and assure you that we will do our utmost to provide you with the best care possible. We also would like to explain our financial policy as it relates to your responsibility for the account.

Patients without Insurance Coverage
Patients without insurance coverage are requested to pay for services as rendered. We accept personal checks, cash, AMEX, Discover, Mastercard and Visa.

Patients with Insurance Coverage
Our office will be glad to help you obtain the appropriate benefit from your insurance carrier as a courtesy to you. However, you are responsible for the payments on the account.

We do our best to provide you with an estimate of the co-insurance payment by you. However any balance not paid by the insurance company will be your responsibility unless stated by your carrier. Even if you have dual coverage (this is possible if you and your spouse both have insurance), there may still be a portion that will be your responsibility.

If you are having treatment over a period of time, we would appreciate payment during the course of treatment. Our office manager will assist you in arranging a payment schedule.

Additional Terms
Customer hereby acknowledges and agrees that any account that becomes delinquent will be subject to collections service. Customer agrees to pay all court costs and reasonable attorney fees for collection of all past due amounts owed, plus interest thereon at 18% (eighteen percent) per annum on all such amounts outstanding. There will also be a $35 service charge on all returned checks and additional charges for cost of collection.

Finally, be assured that we are all here to serve you with the best care possible. When leaving our office, you should leave with the feeling that all your questions have been answered.

I HAVE READ THE ABOVE AND UNDERSTAND THE FINANCIAL POLICY OF GREELEY DENTAL HEALTH.

________________________________ ________________________________
Signature of Patient or Guardian Date