

AWESOME Dental Stapleton

PATIENT INFORMATION – Please Print

Full Name _____ Preferred Name _____
 Phone _____ Email _____ DOB _____ Age _____
 Address _____
 City _____ State _____ Zip _____
 Sex ___M ___F ___ Married ___ Single ___ Divorced ___ Separated
 Social Security Number _____
 Occupation _____ Employer _____
 Emergency Contact – Name: _____ Phone _____
 Other parties authorized to discuss your dental information? _____
 Who may we thank for referring you? _____

DENTAL HISTORY

Reason for today's visit _____
 Approximate date of last dental visit _____ Date of last dental X-rays _____
 Previous dentist _____
 What did you like/dislike about your last dental visit? _____

MEDICAL HISTORY

Check if you have or have had any of the following

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Blood Conditions | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Bowel Disorder | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Sexually Transmitted Disease (STD'S) |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Liver Disorder | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Artificial Joint(s) | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Migraines | <input type="checkbox"/> Tobacco |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker | |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Recreational Drug Use | |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | |

Currently taking any medication? If yes please list:

Physician's Name _____ Date of last visit _____

Have you had any serious illnesses or operations in the last six years? ___ Yes ___ No

If Yes, please describe:

Any allergies? ___ Yes ___ No

If yes please list: _____

WOMEN: Are you pregnant? (YES / NO) Nursing? (YES / NO) Taking birth control? (YES / NO)

IF A MINOR, RESPONSIBLE PARTY (PARENT/GUARDIAN, PAYOR)

Person responsible for minor _____

Relationship to patient _____

Address _____ Phone _____

Driver's License # _____ DOB _____

AUTHORIZATION AND RELEASE

To the best of my knowledge, I certify the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, has had a change in health.

Signature _____

Date _____

Please print name of Patient, Parent, Guardian or Personal Representative

Relation to Patient

AWESOME Dental Stapleton

FINANCIAL POLICY

Please read the following:

- I am responsible for all charges on my account including charges not covered by my dental benefit plan.
- Payment is due at the time of service unless otherwise arranged.
- Awesome Dental Stapleton accepts cash, checks and most major credit cards.
- Any outstanding balance must be paid to avoid cancellation of existing future appointments. Any account over 90 days may, at our discretion, be forwarded to a collection agency
- There will be a \$25.00 fee for returned checks (NSF).

INSURANCE

Awesome Dental Stapleton is contracted with most major PPO dental insurance plans as well as Colorado Medicaid/Dentaquest. As a courtesy, we make every effort to verify eligibility and gather plan information before appointments.

Please read the following:

- If insurance coverage cannot be confirmed at the time of service I am responsible for payment in full.
- Services not covered or have reduced reimbursement(s) by my insurance will be my responsibility.
- I understand it is my responsibility to provide Awesome Dental Stapleton with current dental insurance information as well as provide updates on any changes.
- Awesome Dental Stapleton cannot guarantee payment from my dental insurance provider.
- I understand Awesome Dental Stapleton provides estimates of treatment costs (fees, deductible, co-payments, etc.) however estimates may change depending on insurance guidelines.
- I may receive a balance due statement for any difference(s) once insurance payments have been made.
- I understand that my PPO dental plan contractually obligates Awesome Dental Stapleton to follow their guidelines including fees charged for services provided. No discounts can be given consideration due to this legal arrangement.

INSURANCE AUTHORIZATION AND RELEASE

I certify that I, and/or my dependents(s), have insurance coverage with _____ and assign directly to Awesome Dental Stapleton all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges paid or not paid by insurance and authorize the use of my signature on all dental insurance submissions.

Awesome Dental Stapleton may use and disclose my health care information to the above named insurance company and their agents for the purpose of determining insurance benefits, obtaining payment for services or obtaining benefits payable for related services.

Signature _____

Date _____

Please print name of Patient, Parent, Guardian or Personal Representative

Relation to Patient

AWESOMEDental Stapleton

**3600 Quebec Street
2nd Floor
Denver, CO 80207**

HIPAA Notice of Privacy Practices Acknowledgment

I, _____, hereby acknowledge that I have read and understand
(Printed Name)
Awesome Dental Stapleton's HIPAA Notice of Privacy Practices and/or have been given the opportunity
to receive/read a copy of said practices.

I understand that Awesome Dental Stapleton's HIPAA Notice of Privacy Practices may change
periodically and that I am entitled to receive a copy of such revisions upon request. I understand if I
have questions about Awesome Dental Stapleton's HIPAA Notice of Privacy Practices, I may contact
Dr. Jack Nguyen at (303) 355-1818.

I understand it is my right to refuse to sign this Acknowledgment should I so choose. I understand
Awesome Dental Stapleton will not refuse treatment if I refuse to sign this Acknowledgment. I further
understand that I may contact the Secretary of the U.S. Department of Health and Human Services
should I have concerns regarding Awesome Dental Stapleton's privacy policies and procedures.

Patient Signature

Date

Print name of patients representative

Signature of patient's representative



Appointment Policy

We are happy you have chosen Awesome Dental Stapleton as a partner in meeting your dental health needs. When you schedule an appointment at our office we reserve a specific time for you to be seen by our team at Awesome Dental Stapleton. We spend time and energy preparing for your visit and anticipate that you will keep your scheduled appointment(s).

Changes to Appointment

We understand that plans change and that you may need to alter your scheduled appointment. We ask that you make every effort to give us the courtesy of **2 business days notice** to reschedule or cancel appointments. This courtesy will allow us to offer the appointment time to another patient in need.

We respect our patients' time and make every effort to remain on schedule. On occasion, we may run late with an appointment due to an unforeseen complication. If we are significantly delayed, every effort will be made to notify you beforehand so you may choose to come later or reschedule.

Late Arrival

Late arrivals can disrupt our schedule and inconvenience other patients as well as our staff. Please allow for travel time to our office and arrive at or before your scheduled appointment time. Your late arrival affects our ability to complete the scheduled treatment and doing so may result in your appointment being altered, delayed, or even rescheduled for a different day. A Broken Appointment Fee may apply at our discretion.

Broken Appointment Fee

A minimum charge of **\$40.00** will be applied for appointment changes made with **less than 1 business day notice at our discretion**. This fee may also apply to a late arrival in the event we are unable to see the patient due to time constraints. All Broken Appointment Fees must be paid before treatment is provided.

BY SIGNING BELOW, I ACKNOWLEDGE AND AGREE THAT I HAVE READ, UNDERSTAND, AND WILL COMPLY WITH THE APPOINTMENT POLICIES OF AWESOME DENTAL STAPLETON LISTED ABOVE.

SIGNATURE OF PATIENT/PRIMARY INSURED/LEGAL GUARDIAN

DATE

PRINTED NAME OF PATIENT